MAY - JUNE 1959

# children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

**Childhood Accidents**

**Rheumatic Fever Prevention**

**Working With Delinquents**

**Conference on Homemakers**

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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SAFEGUARDING CHILDREN at a street crossing, this member of a school safety patrol is helping to cut down on motor vehicle accidents, the major cause of deaths from accidents among children.

With accidents of all types the leading cause of children's deaths in the United States and the source of an untold number of permanently handicapping injuries, accident prevention was the focus of attention this year on Child Health Day, May 1. Some questions that must be asked in planning a program to prevent childhood accidents are presented in the lead article in this issue.

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In Tacoma, Wash., since 1953, Howard Rosen not only heads the social work activities in the local health department's child guidance clinic, but also serves as coordinator of the department's mental health division. A graduate of Tulane University's School of Social Work, he practiced psychiatric social work in New Orleans and with the U.S. Army before taking a third year of training, at the University of Pittsburgh, specializing in community organization.

Katharine Brownell was engaged in clinical pediatrics until part-time service on a Children's Bureau wartime project stimulated her interest in public health. Subsequently she served for 3 years with UNRRA in Greece, becoming deputy health director of the mission. She has been with the Manhattan cardiac program since it began in 1958 as a demonstration project on New York's Lower East Side. She is on the faculty of New York University's College of Medicine.

Psychologist Jacob Chwast credits the development of the ideas expressed in his article to his participation in the Interprofessional Committee on Treatment Practice with Delinquents, a group of New York social workers, psychologists, and sociologists, who in 1957 and 1958 held interdisciplinary institutes on the therapeutic problems of work with delinquents. Lt. Chwast is consultant on delinquency for the Association for the Psychiatric Treatment of Offenders.

Before coming to the Children's Bureau 3 years ago Ursula M. Gallagher, a graduate of Western Reserve University, School of Applied Social Sciences, was executive assistant at Catholic Social Service in San Francisco. Previously, she worked in both public and private children's agencies in Cleveland as caseworker, supervisor, and supervisor of social-work students in field-work placement.

For the past 7 years psychologist Irving Sigel has been directing a project at the Merrill-Palmer School which is concerned with the influence of adults in modifying the behavior of children. In addition to several papers reporting on this project, prepared with his associates, he has written many articles for professional journals.

## ◀ *the authors*

*What to consider in planning a program to prevent . . .*

# CHILDHOOD ACCIDENTS

JAMES L. GODDARD, M.D.
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IN THE PAST TWO DECADES there has been growing concern over the health problems created by accidents and in particular those accidents involving children. Many groups have voiced this concern at various times—pediatricians, schoolteachers, surgeons, parents' groups, national voluntary agencies, and, quite properly, public health agencies at all levels.

Those of us who are part of these groups know one of the major reasons for this concern—accidents are the leading cause of death for all ages between 1 and 35. They have attained this position as the result of the triumph in this century over those ancient enemies of childhood, the contagious diseases.

Thus, accidents have not actually risen to the top of the death cause list. Rather they have been uncovered, as rocks are left uncovered by receding waters at low tide. Like the rocks they are no less real because they have recently been revealed. It is no less our duty to cope with them.

We are not only concerned about the loss of 10,000 children ages 1 to 15 each year through accidental deaths; we are also intimately involved with the problems of children who are crippled, maimed, or disfigured by accidents. The extent to which each of us is involved varies from region to region and depends in many instances on how people obtain health services. The National Health Survey gives us some idea of the dimensions of this part of the problem. Estimates based on the first year of the survey indicate that some 17 million children sustain accidental injuries each year.

Here, further, are some significant details regarding injuries to children:

1. Home accidents are a preponderant source of injury. The motor vehicle is a relatively insignificant factor in this age group.

2. Boys are involved in a disproportionate number of injuries—almost twice as many as the injuries to girls. This disproportion begins shortly after the first year of life and increases thereafter; in the age group 10 to 14 the boys have almost three times as many injuries as girls.

3. The frequency of injury among both sexes is far greater than we had previously estimated. Among males under 15 years, 4 out of 10 suffer some sort of accidental injury each year. Among females, the casualty incidence is 2 out of 10.

There are marked differences between injuries which produce death and those which children survive. The significance of these differences becomes apparent when plans for preventive programs are considered. Analysis of death certificates shows motor vehicle accidents, drowning, fires and explosions, and obstruction and suffocation as the four major accident categories in which children are involved. When morbidity data are examined, falls, cutting and piercing instrument injuries, blows from objects, and animal bites are the major types of accidents to be considered. Motor vehicles are fifth.

Two other sets of facts are worth attention in this

Based on a paper presented at the 1958 annual meeting of the American Public Health Association, St. Louis.

sketchy profile of accidental injuries involving children.

The first pertains to the nature of the injury. An analysis of 7,811 emergency room cases and hospital admissions of children in a northeastern community showed that lacerations, contusions, and fractures are the most frequent types of injuries. Burns and scalds are also frequent in children under 5 years of age.

The second set of facts describes the injuries to parts of the body and according to age group. These reveal that injuries to the head are a major problem in childhood accidents. For the under-1 age group, 6 out of 10 injuries are head injuries.

Even from this limited data we can draw one conclusion—we are dealing with a complex problem which will require us to seek multiple solutions.

### *Causative Factors*

The causative factors of childhood accidents are largely unknown. There is a belief that we must to a large extent relate these factors to the patterns of growth and development if we are to achieve the understanding necessary to develop effective preventive programs.

The micro-society of the child can be studied through use of the epidemiologic technique. A study of the child will, I am sure, be unproductive if we fail to consider the concomitant stages of growth and development. Any study of the diverse agents involved will be unproductive also if due attention is not paid to their possible interactions with the child. And the environment, whether it be the crib or the expanding universe of the teenager, must undergo systematic scrutiny.

Above all, our understanding of causative factors will develop only as rapidly as we are able to extend our concern beyond the immediate events surrounding an accident. We must view accidental injuries as the end point of a chain of circumstances and events. This means we must be more concerned with the dynamics of accident causation. We must examine such background factors as training, experience, judgment, and the physiological and mental elements; we must study patterns of operation within given environments and the changes occurring in these patterns of operation.

At this point, a word of caution! Pediatricians, psychiatrists, and other experts in child behavior are beginning to warn us that there may be a definite hazard associated with the efforts to study and prevent childhood accidents. We may, they state, arouse new anxieties in parents which they will transmit to the children. A resulting sense of insecurity among children could increase their accident susceptibility and thus defeat our very purpose to minimize accidents. How then shall we proceed?

### *Secondary Prevention*

There are two avenues to travel in attempting to reduce death, injury, and disability from childhood accidents. The first is to participate in efforts to ameliorate the effects of accidents. Prevention of deaths from secondary causes and prevention or modification of disabilities are aspects of the problem which cannot be neglected. The virtue of this approach is that often we can produce rather immediate results and perhaps, what is even more important, gain know-how which will facilitate solutions of the more difficult problems posed by primary prevention.

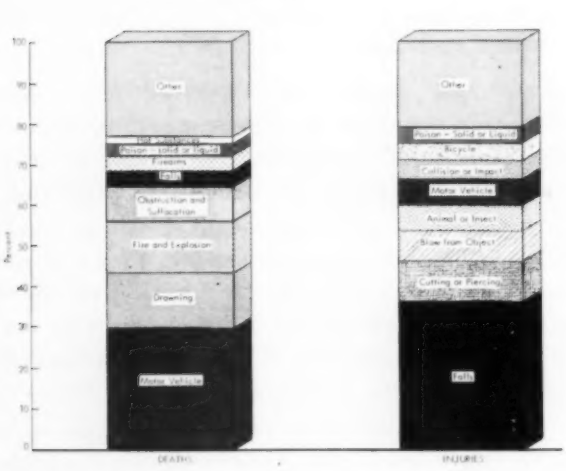
In regard to secondary prevention, three of many activities might be considered:

1. ***Poison control.*** Rather than dwell on the phenomenal developments that have taken place in the development of poison-control centers during the past 5 years, one may merely ask the question, "Do all the physicians in the community have access to such a center?"

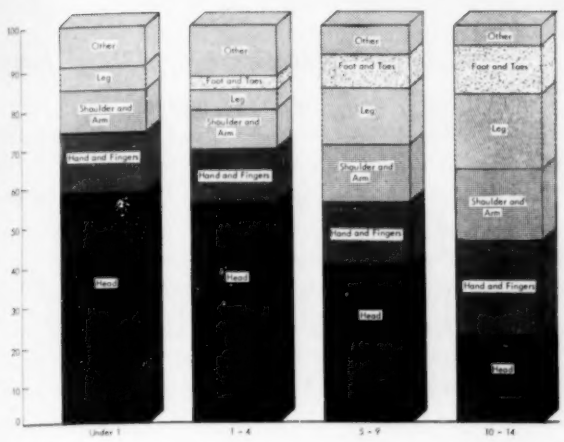
2. ***Prevention of drowning.*** An important development in the prevention of deaths from drowning is the new method of mouth-to-mouth resuscitation. This

**LEADING CAUSES OF ACCIDENTAL DEATHS AND INJURIES**

**Persons under 15**




**The first column shows deaths recorded in the United States as a whole in 1956. The injury column is based on data for July 1957–June 1958 collected in one northeastern city.**




**The columns show, according to age groups, the part of the body primarily injured in children treated (July 1957–June 1958) in hospitals in one northeastern city in the United States for injuries suffered in accidents.**

method has been proved to be far more effective than the several techniques most of us learned in the past. A good question is: "Are public health workers prepared to teach this method?"

3. ***Emergency care.*** It has been conclusively demonstrated that the quality and distribution of emergency care for accidents of any type significantly influence the survival rates, length of hospitalization, and degree of disability. The importance of careful handling of the victim from the time of injury until definitive care begins is appreciated strongly by the surgical profession. Unfortunately, the urgency for such care has not always been communicated to those responsible for emergency services. So the question must be asked: "How adequate are the emergency services in the community?"

There are three major elements in this question which should concern the community health agency as much as the practicing physician. They are: (*a*) training of personnel; (*b*) adequacy and amount of equipment; and (*c*) distribution of the service in relation to the population and the facilities used by the population.

Providing positive answers to these questions need not be difficult. More important than detailed solutions and blueprints for action is willingness to accept responsibility for these aspects of community health problems.

### *Primary Prevention*

As all of us concerned with public health move down this first avenue, achieve recognition and support, and clean up these "foci of infection," we will find the means to tackle the problems of primary prevention. There are certain principles which we must keep before us as we undertake this portion of our task. They are five in number: (1) better definition of the problem; (2) education; (3) coordination of activities with other agencies; (4) development of appropriate legislation; and (5) conduct of needed research. The reasons behind these principles are obvious and well understood, but in our anxiety to do something we often forget their importance.

In approaching the total problem of primary prevention of childhood accidents, I would stress to health workers in particular these observations:

1. Without better definition of the problem, we can dissipate our energies.

2. Failure to carry out the needed research will lead to erroneous assumptions. These assumptions in most instances will permeate our educational activities and in most instances lead to failure.

3. Education will be the keystone of success. We will only succeed if we can move from the general to the specific.

4. Legislation in special instances can eliminate or reduce hazards to children. Legislative proposals must be based on facts and be capable of being implemented.

5. Coordination of activities with other agencies and groups will be essential. When you begin to develop program activities for the prevention of childhood accidents, you will run into the problems created by division of responsibility.

Problems can be developed into opportunities by digging in and doing the hard work that will be needed to provide leadership.

*A child guidance clinic finds an aid to therapy in . . .*

# CAMPING FOR THE EMOTIONALLY DISTURBED

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FOR THE LAST four summers, the Tacoma-Pierce County (Wash.) Health Department's child guidance clinic has conducted a camp for emotionally disturbed children. It has, as the following description of the 1958 experience shows, combined a therapeutic emphasis with normal camping activities.

The emotional illnesses coped with most successfully were (1) anxiety states, (2) anxiety hysterias, (3) conversion hysterias, and (4) compulsion neuroses. Many of the symptoms exhibited by children during their evaluation for camp admission were: "lack of confidence; infantile behavior; passive-aggressive behavior; preoccupation with illnesses; tics or habit spasms; fidgetiness; hyperactivity; disorders of speech; and finger sucking." These were reduced significantly in the camp by placing emphasis on: (1) relationship with adults—the camp contained an average of two children per adult; (2) relationship with peers in a small group; (3) consistency in the enforcement of a few necessary rules; and (4) a program aimed at making it possible for every child to achieve some success in physical and creative efforts and in interpersonal relationships.

Because the program has proved in many instances to be an effective aid to therapy it will be offered again this year, though community groups will assume sponsorship, releasing the clinic from responsibility for raising funds for camperships, community interpretation, and financial and business management.

The camp uses the facilities of a YMCA camp located among 140 acres of natural forest on a small cove on Puget Sound. In 1958 it included 48 children—8 cabins of 6 children each, ages 7 through 13, both boys and girls.

## *Staff Selection*

The clinic had learned in past years that the two most important prerequisites for a successful camp program are careful selection of staff and of children. Therefore, in 1958 it recruited 30 percent of the camp staff—all of the senior counselors—from the teaching and guidance staffs of the public schools, on the basis of their maturity, their warmth, their child-oriented training, and their ability to offer wholesome adult identification for the child. Another 30 percent—most of the junior counselors—were outstanding leaders from the regular staff of the YMCA camp, mostly college students. They had the advantage of thorough acquaintance with the physical aspects of the camp, its resources and surroundings, camp songs, camp lore, and campcraft. Other counselors came from nearby colleges and a school of nursing. In addition, the camp employed an arts and crafts director, a waterfront director, and a music therapist. Every staff person was interviewed individually in the child guidance clinic in order to find those with personalities most suitable for the camp objective.

Two psychiatric social workers shared responsibility for providing regular consultation to the staff every evening. One was assigned full-time to the camp. His responsibilities were first of all to be

available for "on the spot" consultation with staff or for direct intervention with children experiencing an emotional crisis. Secondly, he was a program consultant to the camp director. The other psychiatric social worker lived in camp but worked in the clinic during the day and was the liaison staff person between clinic and camp. The clinic's psychiatrist spent a day and an evening in camp consulting with the staff.

The camp coordinator and director was a teacher in charge of guidance in a junior high school who had been at the camp in the same capacity for several years. His responsibilities included: developing the program in consultation with the social worker; coordinating staff activities; making assignments to the staff; and coordinating activities with the business manager, who was responsible for supplies.

### *The Children*

In selecting children for the camp, the clinic was guided by past experience, which indicated that the child with symptoms such as shyness, infantile behavior, lack of confidence, fears and hypochondriasis seemed to benefit most visibly from the camp experience. This, we believed, was due to the milieu therapy and a ratio of staff to children which made individual child-adult and child-child relationships feasible.

Experience has shown that children exhibiting symptoms of aggression and hostility were able to benefit from the camp experience if the ratio was controlled—one, or at the most two such children per cabin. Such children presented a considerable strain on the counselors as well as on their cabin mates. We had also learned that children who had difficulty in expressing hostility seemed to benefit by association with an aggressive child as long as sufficient and consistent control was maintained.

On the other hand, we had learned that children who acted out severe aggression in antisocial behavior were not suitable for our camp because of their driving need to test the camp's staff repeatedly to the point that they required continuous attention. Other children not accepted were those whose contact with reality or amount of intelligence was not sufficient to enable them to comprehend and follow the camp's safety rules.

Children were referred for camp by child guidance clinic therapists, as well as by public health nurses, social workers of other agencies, ministers, physicians, the children's service of the State hospital, and other child guidance clinics in the vicinity. Some parents read in the local newspaper about the camp or heard about it from friends and applied to the clinic directly for camp admission. Procedurally, a child applying for camp was evaluated in the same way any other youngster applying for child guidance services. But in the evaluation, we paid special attention to whether the child's emotional needs were of a type likely to be met in a camp setting.

### *Preparation*

Once the children were selected, the next step was to divide them into cabin groups of six, taking into consideration a variety of factors. Since our aim was to form a cohesive group—mental age was of more importance than chronological age. We considered a balanced group to be one including one or two youngsters exhibiting a tendency to dominate and be aggressive; several whose major problems were shyness and withdrawal; perhaps another with hypochondriacal preoccupation, fears, and phobias; and one with a great need to be accepted.

With this type of balance, the children could, with the help of the staff, interact with each other for their mutual benefit. The group process seemed especially helpful to the shy, withdrawn youngster, who with some understanding of the behavior of his aggressive cabin mates as well as his own, became able to assimilate some of the aggressive behavior he observed; but the reverse was also true to a more limited extent.

From the second year on, we placed a senior and a junior counselor in each cabin of six children. During our first year, we had one cabin counselor per six children in addition to the auxiliary staff. The children were not able to form the adult identification at which we aimed and the counselor was too exhausted from the many demands, emotionally as well as physically, placed upon him. Additionally, our nightly staff development programs did not function satisfactorily.

Once the cabin groups were selected, we arranged for the groups to meet in the clinic prior to camp so that the children would get to know each other. In 1959 we are carrying this arrangement one step further. The two counselors are meeting with their respective cabin groups so that the children not only learn to know each other, but also meet the adults with whom they are going to live.

The meetings provided an opportunity for the clinic staff to test their hypothesis that the children in each group would derive a therapeutic benefit

from living together. The meetings also gave the staff a chance to spot and withdraw from the plans the few youngsters who were too uncontrollable and disruptive to fit into the camp program. Because of this precamp observation, we found it necessary in camp to move only a very few children from one cabin to another.

While the children met in groups at the clinic, the mothers met there at the same time. Thus they had an opportunity to raise questions, get answers, and, to some degree, learn to deal with their anxieties regarding camp. The attitude of some overprotective mothers in these groups was very revealing of some of the reasons for the child's difficulties. The group was frequently able to offer some relief to the mother's anxieties.

Inservice training for the staff started in camp 2 days before the arrival of the children. Its main purpose was for each member of the staff to learn the role of the other members and to learn to function as a member of a team focusing upon the emotional needs of the children. The training sessions described clearly the lines of authority but, at the same time, emphasized the point that the success at camp depended on each individual's contribution. The purpose of the camp's nightly staff meetings was defined not as critical evaluation of one another's work, but as exchange of ideas in an atmosphere conducive to a free discussion of problems.

The social worker who led the discussion in these training sessions, as in the ensuing nightly staff meetings, encouraged an atmosphere where positive and negative feelings could not only be voiced but were also considered essential toward growth and understanding. He helped the counselors see that because they would be living with the children, they would be more real to them than the clinic's therapist. The social worker also spent the last half day of the training in individual sessions with each senior and junior counselor to acquaint them thoroughly with the problems and needs of each of their children, making some suggestions about how to meet them.

### *Program*

The program was designed to increase maturity by cabin group discussions and psychodrama—which provided outlets for hostility as well as opportunities for insight—by the development of group cohesion, and by finding success through a variety of media. Its activities did not differ greatly from that of a regular camp. The main difference lay in the greater amount of time the children spent with their own cabin groups. However, interwoven in all the activities were the elements of interpersonal relationships and ego-building goals. For example, a poorly coordinated youngster was given sufficient help by one of his counselors to be able to row a boat and so to experience the feeling of mastering a physical activity.

All activities were permeated with meaningful relationships with adults who not only enabled each child to find success in something, but who also provided him with an opportunity to find acceptable outlets for drives which needed to be expressed. For example, the arts and crafts director encouraged some of the shy children to build simple musical instruments. The music therapist then formed a rhythm band, thus helping the children to use a medium of expression to find success.

There was no organized competition in camp except for daily cabin inspection, when recognition was bestowed upon the neatest cabin. There were a few camp-wide programs—trips to nearby islands or other points of interest, swimming, a "Pirates Day." Other activities included fishing, boating, hiking, ballplaying, cookouts, and overnight campouts.

A rest hour after lunch was often used for cabin discussions with the purpose of helping the children to participate in the give-and-take of daily life and to learn to cope with some of the problems which always arise when people live together.

These cabin discussions focused on such questions as: "Why do some youngsters not care to take part in an activity? Is there some way for us as a group to enable them to participate? What shall be done with the youngster who does not clean up his bunk so that the cabin gets a reprimand during inspection?" Usually these discussions were guided to some degree by the leaders in efforts to: (1) deal with reality problems facing the cabin group as well as the individual; (2) create more understanding in the children of themselves and others; and (3) increase group cohesion.

Each child served on one of three camp committees, which met every other day—a camp government council, a campfire committee, and a religious services committee. Each committee had two staff advisers. The committees' purpose was to give the children a voice and a role to play in camp, and also to expose them to democracy in action. Special efforts were made to enable the shy children to contribute to the committee discussions.

The camp government council discussed such sub-

jects as camp regulations pertaining to water safety and how to deal with offenders. Occasionally, the children complained about the rules. Some of their complaints were realistic, but in the discussion the children often expressed their personal needs of either supporting or siding against authority. We believed that the children benefited from listening to several sides of one issue and observing how a decision was based on the interests of the majority. Such discussions produced valuable data for the clinic records as well as subjects for future cabin discussion.

The campfire committee planned the programs for the nightly get-togethers around the campfire—singing, storytelling, skits, and acrobatics. One of the members was Paul, a scrawny little 8-year-old boy with large thick glasses, who at times had great difficulty with his speech. Diagnostically, he had impressed the clinic as suffering from a neurosis affecting his conception of himself, his control of elimination (he was a bed wetter), and his social adjustment. One afternoon, at the committee meeting, he volunteered to be the master of ceremonies for the campfire that night.

Paul did a wonderful job that night and from then on became very active in the campfire programs, having found in them a source of satisfaction and recognition. His enuresis decreased and his relationship with his peers improved markedly. A former need to associate with adults decreased as he found these other satisfactions. Paul's mother, still a participant in a group therapy project in the clinic, seems to have been able to sustain his progress.

The senior and junior counselors met on alternate evenings for 2 hours with the psychiatric social workers, the camp director, the music therapist, the arts and crafts director, the nurse, the waterfront director, and on one occasion with the psychiatrist. There, each counselor reported on his six campers, the progress they made, the problems which arose during the day and the night before; and the group helped the counselor to develop plans and ideas which would bring further gains for the camper. For example, at one meeting a counselor, rather embarrassedly, told about being asked by two of his 8-year-old boys to kiss them goodnight. Then, another counselor related an identical experience. In the ensuing discussion a few counselors seemed to consider such requests "unmanly" and were doubtful about how to handle them, but as the pros and cons were considered the two counselors involved developed enough ease to be able to deal with the children's request in a positive manner.

In other discussions the group helped certain counselors to accept campers who had enuresis or soiling problems and at the same time developed ideas

**A rhythm band (left) and two anglers (right) at the Tacoma child guidance clinic's camp for emotionally disturbed children. The camp, attended largely by shy, withdrawn children, stressed activities through which the children could experience a sense of success or take their first tentative steps toward companionship without the risks of competition.**

on how to deal with the feelings of other campers regarding these problems.

The precamp medical examination showed very few children actually in need of daily medication except for those for whom sedatives, tranquilizers, or anticonvulsants had been prescribed. Nevertheless, some hypochondriacal children of overprotective mothers arrived in camp with assortments of patent medicines and rigid directions from their mothers about taking them regularly. Very gradually, as the camp experience met more and more of their needs, the interest of these children in taking medicine subsided, in some to the point of forgetting about it completely.

### *Signs of Improvement*

Milieu, program, and interpersonal relationships were the therapeutic tools of camp. Three examples demonstrated their effect:

**Tom.** Tom, a 10-year-old, and his parents had been receiving treatment at the clinic for 4 months before he came to camp. He had been referred to the child guidance clinic because of vomiting attacks without organic cause for 3 years and with a history of showing no normal aggression. In the clinic he impressed us as a fairly anxious boy who was not able to relate to others easily. The therapist found him preoccupied with fantasies of aggression toward his brother, involving various unpleasant, dangerous, and destructive activities, but full of anxiety about his own aggressive impulses.

At camp Tom was at first very reserved and reluctant to participate in any aggressive activities. On the fifth day, he began to take part willingly in nonaggressive games and seemed to want to please the counselors in every way. On the eighth day another youngster selected him as a target for his aggressive needs. Tom asked his counselor whether he could fight back. He was given permission to do so and proceeded, upon the next provocation, to get involved in a regular fight. He won, and from that day on began to show leadership qualities. He accepted responsibility well and identified closely with the counselor, supporting him in all issues and keeping very close to him. He still would not participate in aggressive games.

The full-time social worker was also Tom's therapist in the clinic and was aware of the boy's difficulties with his aggressive feelings. In subsequent interviews with Tom and his parents, the social worker learned that Tom had had a 3-day vomiting spell shortly after his return home and that he had not told his parents about his fight because he thought they would disapprove of it. His feeling about the fight kept the focus of his treatment hours upon the acceptance and eventual control of his hostility, with good progress.

**Richard.** Richard, age 7½, had also been in treatment at the child guidance clinic before going to camp, as had his father and mother. He had been referred there by his school because of poor school work, infantile behavior, lack of interest, lack of bowel control, and withdrawal. Although Richard had been born prematurely—in the seventh month of his mother's pregnancy—complete physical and neurological examination at the time of his admission to the clinic revealed no abnormalities. Psychometric tests showed him to be functioning on the level of dull-normal intelligence. Richard's mother showed evidence of being greatly overprotective and also somewhat overcome by the responsibility of raising a second child. His father, a professional man, who had been studying at night for many years, seemed to be a very dominating person who nevertheless harbored deep feelings of insecurity and anxiety.

The decision to send Richard to camp had been based on the hope that the therapeutic milieu would stimulate his emotional growth and provide him with opportunity for masculine identification.

At camp Richard at first asked questions continually and at times wandered around seeming not to comprehend what was going on. In the relations he had with the other campers he was never more than a follower. Often he embarked on little isolated projects with paints or clay. However, as he probed his new environment and witnessed his counselors' permissiveness and consistent discipline, he was increasingly able to express directly some of his hostile and destructive wishes.

Opportunities to act out a feeling without suffering consequences were therapeutic for Richard, since at home he did not have them. Slowly, his fear of human contacts and his disbelief in his capacity to achieve gave way to an ability to develop a degree of relationships with other children and to a willingness to test and explore new activities such as fishing, boating, and playing in the water. Throughout the 12 days, he was required to follow the camp rules consistently. Though he was at first very slow in such activities as setting the tables in the dining room, cleaning the cabin, or taking a shower, he soon

showed that he knew that certain procedures were expected of him and the others, and that he could comply.

Not only were considerable therapeutic gains made with Richard at camp, but the knowledge secured through observation of him there was invaluable to the clinic in planning further work with him and with his parents. It was also of great help to his classroom teacher, with whom the clinic held a conference at the beginning of the next school term.

**Garry.** Thirteen-year-old Garry, whose chief problem was lack of impulse control, had had no treatment at the clinic before going to camp, having been referred by the school at the end of the term. He was the younger of two brothers. Their father, who had always rejected Garry, had died years previously. Their mother required continuous bolstering, emotionally and economically, in order to be able to keep the family together. At camp Garry at first tried to present himself as a successful youngster without any problems. On the second and third day, his difficulties came out in the open when he began bullying, refusing to participate in cabin activities, and making jokes of the program. His reaction to discipline was loud and boisterous joking, and only after testing the counselors' patience to the limit would he meet social demands.

For the first 6 days, Garry was a serious strain on his cabin counselors and a poor influence on another boy who had similar problems. Then an opportunity for dramatic intervention in his personality problems presented itself when his cabin group and others went on a 2-day hike. While climbing a steep, rocky mountainside, Garry, when nearly at the top, suddenly froze and refused to move. He became very agitated and fearful of falling, cried, and called for his mother. Instead of the loud, boisterous bully, he was a little boy afraid. The psychiatric social worker stepped in immediately to help Garry to control his fear and later used this incident to help him with his perpetual feelings of inadequacy. Garry was never again the same bully in camp, except for very brief periods. His cabin group did not allow him to continue the role.

A great deal of communication took place between the social worker and the leaders of Garry's cabin group in order to coordinate their efforts in his behalf. Garry is now attending the clinic and responding well to treatment, but without the opportunities and understanding provided by the camp experience the prognosis would have been less hopeful than it is.

### *Followup*

The counselors wrote reports on each camper. This material, together with the social worker's observations, was used in clinic conferences with the parents of each camper after the camp closed. In these conferences the parents were informed of their child's adjustment in camp as well as of his continuing needs. Complete camp reports were also sent to the referral sources.

A few children attended camp without receiving any treatment either before or afterward. Others continued treatment previously begun with the guidance clinic or with the referring agency, such as the school counseling division or a family agency, the clinic providing consultation service and a report of the camp observations. Some children who had had no prior treatment anywhere revealed a great need for treatment through their behavior at camp. The clinic has, with some success, attempted to stimulate their parents to secure the needed treatment for them either at the clinic or elsewhere.

Our experience has indicated that to be successful such a camp requires coordination with the referring community agencies and services to whom the child might return for further treatment. This not only helps the child, but also gives the referral sources an interest in the camp and a willingness to participate in the annual camp planning and preparations.

An important by-product of the total camp experience is the philosophy and understanding the counselors develop while at camp. This understanding is passed on, in varying degrees, by the individual staff members to their students if they are teachers or school guidance personnel, or to their classrooms and into their future professions if they are college students.

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**Immature adult behavior and a shirking of responsibility toward youth has provided much of the confusion that disturbs the juvenile—who has a much better right to be immature.**

New England Journal of Medicine, *September 25, 1958.*

# A PROGRAM TO PREVENT RHEUMATIC FEVER RECURRENCE

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CLINICAL OBSERVATION indicates that this country is experiencing a decline in the incidence and severity of rheumatic fever, a trend associated with and probably closely related to the rising standard of living of most of our population. Nevertheless, this disease—whose most frequent victims are children—still represents an important public health problem. Though less prevalent now than formerly among those whose living conditions are good, the incidence may well be as high as ever among indigent or marginal income families—those who live under crowded, unhygienic conditions which promote the spread of streptococci—the very people who, when handicapped by illness, put the greatest demands on the community for support.

This is particularly true in urban areas where large groups of people live in congested slums. Because this population is unstable and moves frequently, followup is difficult. The people in these areas generally obtain their medical care through clinics, or in cases of emergency from practicing physicians most of whom do not attend medical meetings, read medical journals, or have teaching hospital appointments. These people tend to shift from one clinic or physician to another. They have little concept of health as a positive attribute, and seldom consider payment for health supervision to be a justifiable expense. They are difficult to reach through health-education programs. But they are the people whose children produce the largest number of cases of rheumatic fever in metropolitan areas today.

A city has a greater variety of resources for reaching this difficult group than is commonly found in the small town or rural area. It has organized school health services through which cases can be found; clinics, often under medical school or heart association auspices; numerous voluntary health and welfare agencies providing a wide variety of services. It has a lay and professional population representing many talents which can be called upon to provide leadership in program development.

However, the very existence of many agencies creates special problems. Coordination of agency services is necessary and difficult. Effective communication, relying as it must largely on forms and other written material, is difficult to achieve. But without close integration of services and effective interagency communication it is all too easy to lose sight of the individual for whom the program is planned.

### *Urban Programs*

An urban program will prevent the greatest number of recurrent attacks of rheumatic fever, if it concentrates its efforts—at least in the beginning—on the *indigent* who obtain medical services through clinics and other public services, and on those of *marginal* income who attend pay clinics, or receive private physician care for acute illness, but who cannot afford on a long-term basis the drugs and frequent medical supervision required if recurrent rheumatic fever is to be prevented. Patients in these groups are readily found through organized school health services and through hospital and clinic admissions.

The elements of a program which will reach these groups are:

1. ***The cooperation and understanding of the staffs of all the agencies involved,*** and of the practicing physicians who care for this segment of the population. These agencies include the local heart association (often assuming the leadership, alone or jointly with the official health agency), the depart-

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ments of health, welfare, and education, municipal and voluntary hospitals, voluntary health and welfare agencies of various sorts, and the local medical societies.

Such understanding and cooperation can only be obtained by:

a. *Joint planning* of the program by representatives of all the agencies to participate in it.

b. *A continuing education program* which includes all professional groups concerned, from the practicing physician to the classroom teacher. An educational program cannot successfully be a one-shot affair, particularly in a large city. The practicing physicians involved are difficult to reach. Agency professional staffs change and program procedures are complicated. Unless plans for continuing educational efforts are built into the prevention program from the start, procedures are forgotten, children become lost to followup or do not receive indicated services, and the program grinds to a halt.

2. ***Diagnostic services.*** These are essential in any prevention program focused on clinic patients or on those of the private physician. The difficulties inherent in the diagnosis of rheumatic fever, or of heart disease in children, lead to overdiagnosis more often than to the missing of cases. Unless diagnostic and consultation services are available as part of the program and, more importantly, used, children who have never had rheumatic fever will be registered on the program and receive prophylaxis. A false label of rheumatic fever and rheumatic heart disease, so often resulting in unnecessary restriction of a child's activities to the detriment of his social and emotional development, was serious enough in the past; but now with the possibility that a child so labeled may be placed on indefinite drug prophylaxis it is even more serious.

A consultation service, besides clarifying individual diagnoses, serves as a source of referral to clinics or private physicians of cases not under medical care found by the school physician. It can also serve as an educational tool for the school physician and the practicing physician, and assist the latter in obtaining community services for his patients.

3. ***A good outpatient clinic program.*** Such a program will reach the majority of rheumatic patients in many urban areas. But a good clinic prevention program demands hard work and is often costly. It involves specific planning and, often, reorganization of the usual pediatric or cardiac clinic if it is to be effective. Patients will need to be seen more often (at least once in 3 months probably) than is usual for symptom-free patients. This usually requires an increased medical staff, or longer doctor hours. Successful followup requires clerical staff and sufficient social work and public health nursing staff. The never completed but essential education of patients, which taxes the ingenuity of all professional staff, must be carefully organized.

The reorganization and expansion of a clinic's services, necessary for effective rheumatic fever prevention, require enthusiastic medical leadership in the clinic, good clinic administration, an adequate staff, and the wholehearted cooperation of the administration of the hospital.

4. ***Drugs within the financial means of the patient.*** Whether a patient is cared for in a clinic or by his private physician, prophylactic drugs must be available to him within his ability to pay. A number of different ways in which free or low cost drugs can be provided have been developed in different communities. This of course is an important aspect of any program but is sometimes overemphasized in the development of prevention programs, at the cost of too little attention to case finding, adequate and continuing medical care, education of patients, and followup.

Too often the provision of drugs has been the major aspect of programs to prevent rheumatic fever. Prophylactic drugs are wasted, from the point of view of secondary prevention, if they are consumed by a person who has never had rheumatic fever. They are ineffective as a means of preventing streptococcal infections and recurrent rheumatic fever in persons genuinely rheumatic if they remain in the container in which they are dispensed—where they often do remain in the absence of a good education and followup program!

Moreover, physicians' (and probably patients') preference for the more expensive oral penicillin, instead of the apparently equally effective sulfa preparation which can be obtained at a fraction of the cost, has exaggerated the financial difficulties in the provision of drugs. It is a rare family who cannot afford the cost of two sulfadiazine tablets a day. As a rule, for patients of marginal income the financial problem is less the cost of drugs (important as that may occasionally be) than it is the cost of regular visits to a physician, without which few patients remain continuously on any prophylactic regimen.

5. *Special prophylactic clinics.* Urban communities might explore the possibility of setting up such clinics specifically for the marginal income patients of practicing physicians. These clinics would be for prophylaxis only, the patient remaining under the care of his own physician for everything else. The clinics would provide drugs and the necessary health education and followup services to ensure continuous prophylaxis. They should be as acceptable to the practicing physician for patients at this income level as are well-baby stations, child-health conferences, and health department immunization services.

6. *An organized followup program.* This is the key to an effective rheumatic fever prevention program. Clinics, in spite of their own followup procedures, often fail to get patients to keep appointments, or lose track of them altogether. The practicing physician usually has no followup system at all; he cannot require periodic return visits, he can only suggest them. In New York City the health department has been sending followup questionnaires to physicians of patients for whom prophylaxis has been recommended by the diagnostic service. Time and again these questionnaires are returned stating "patient not on prophylaxis," with the reason checked "patient did not return" or "patient uncooperative."

Program followup may be carried out through the school health service and its public health nurses, or directly by the public health or visiting nurse through a system built around failures to have drug prescriptions filled after the expected interval. But whatever the system, good followup is the key to a successful program, and in most instances the public health nurse is the key to followup.

A word should be said here about the followup of adolescents, particularly in a city relying to any extent on a clinic program. Unless special plans are made to meet the unique needs of this age group, preferably through the establishment of their own adolescent clinics, many of them will be lost to followup on transfer from a pediatric to an adult clinic—at a time they are in need of many services, and the danger of rheumatic recurrences is by no means past.

7. *Administrative agency.* Finally, a prevention program must have a responsible, strong, administrative agency, preferably within the health department, to coordinate all available community services for the benefit of the individual who needs them.

It is the administrative agency to which cases found through any source are reported; which is responsible for keeping track, by means of a case register, of the individual child as he moves, shifts treatment agency, or disappears, as often happens in a large city; which sees that medical care, drugs, and other needed services are available to him.

The administrative agency, through its contacts with service agencies about the problems of the individual child, becomes aware of those areas where special educational efforts are needed, where duplication of effort is taking place, and where agency responsibility needs clarification. It is in a position to determine gaps in service and to stimulate the community to provide the missing services. Through its case register, planned to produce the information needed, it is responsible for frequent periodic evaluation of the program itself.

## *Conclusion*

Although a secondary prevention program in a metropolitan area will reach the largest number of cases soonest if it aims first at the children of school age of lower-income families, it should not, of course, be limited to this group. As the program develops efforts should be made to find all children in the community with a history of rheumatic fever and to make available to them all the services of the program, and to extend the program to adults.

Nor should a secondary prevention program, particularly in an urban area, be limited to the prevention of recurrent rheumatic fever. It is dealing with individuals most of whom are also in need of services other than the prevention of rheumatic fever. Indeed, some of their needs will be the direct result of our preventive efforts. The necessarily close followup and daily medication or monthly injections are likely to produce emotional problems in both the patients and their families, which will need careful handling, and not infrequently specialized services. Some of these children, despite our best efforts, will have varying degrees of heart disease. Some will need special provision for their education—others will need specialized vocational counseling and training. Many will need assistance in the solution of social and economic problems. All will need close, good medical followup.

Plans should be made from the start to use the prevention program as the framework for a comprehensive community program which will find, follow, and ensure all needed services to all children and young people with rheumatic fever or with heart disease, either rheumatic or congenital.

*A psychologist looks for ways to hurdle the obstacle of . . .*

# VALUE CONFLICTS IN TREATING DELINQUENTS

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IN RECENT YEARS, the problem of values has become a critical issue in psychotherapy, casework, and counseling. Values—goal-oriented attitudes arising out of personal and social experiences leading to judgments of behavior as being right or wrong, desirable or undesirable—permeate all human relationships. They are crucial in the treatment relationship.

No matter how one approaches treatment objectives—whether directly, rather indirectly, or passively—the values of the therapist, consciously or unconsciously held, become operative influences in the treatment process. In treating juvenile delinquents, whether in a court, institution, or nonauthoritative setting, values are of the essence, since the client's antisocial behavior runs counter to the values of the community as expressed in its laws, and often to the less formally defined values embodied in social and moral codes.

Treatment can scarcely move forward constructively if there is no coming to grips with value conflicts, not only in recognizing them when they occur but also in finding ways of dealing with them. This necessitates an understanding of the values operative in the lives of the delinquent, on one hand, and of the therapist, on the other, as well as some clarification of goals.

### *Sources of Values*

Of course, values are not spontaneously generated; they are generated from the individual's own experiences and those of the group in which he is reared.

Probably the most potent value-bearing influence affecting the individual is what has been referred to by the Gluecks as "the under the roof culture"—the family.[1] Parental attitudes toward life and society begin very early to shape the goals, ideals, attitudes, and values of the child. In the family are fused various degrees (or distortions) of cultural, national, racial, and religious standards which in many ways govern the family members' expectations. While individual families differ, various subgroups within our social structure exhibit differences in attitudes toward property, chastity, and expressions of feeling and other types of behavior. Because many delinquents come from lower socio-economic groups, the therapist in working with them must fully appreciate that the prevailing attitudes toward schools, jobs, religion, recreation, friends, sex, personal hygiene, clothing, adults, and authority vary considerably between underprivileged and well-to-do neighborhoods.

As opposed to the middle-class orientation toward long-range planning and the deferment of immediate gratifications in attaining goals, values in lower socio-economic groups are apt to emphasize short-term objectives.[2] For many persons of lower socio-economic status, the struggle for survival dictates emphasis on success in meeting immediate stresses in living without looking toward a rather abstract future. An understanding of this makes it easier to appreciate, although not to condone, such attitudes among delinquents of low socio-economic status as "It's all right to take it if you don't get caught" and

The author presents the views expressed in this article as his own and not necessarily as those of the agency with which he is connected.

"It's all right to walk off with it if it's unattached." Such attitudes are reinforced in underprivileged groups by a low capacity to gratify desires created and constantly stimulated through the general culture's omnipresent advertising apparatus and other culture vectors.

A recognition of the existence of value conflicts will help little unless the therapist has a clear conception of both the ultimate and immediate goals of treatment. He has to be clear about the relation of immediate to ultimate goals when such concrete questions arise as: What does a boy wear for a job interview? Should a boy who expects to be a truck-driver finish high school? Or how should a girl act on her first date?

### *Conflicts in Goals*

The problem becomes even more acute when it calls for a resolution of value conflicts within the therapist's (or the agency's) own conception of the purposes of treatment. For instance, practitioners have observed among some delinquents that the giving up of delinquent behavior may be followed by compulsiveness, phobias, and other neurotic or psychosomatic symptoms. This happened to Harold, a 14-year-old boy, who had been involved in several minor thefts and fights. Initially he had appeared independent and hostile, and spoke with but a slight speech impediment, but after 2 years of intensive psychotherapy, during which he discontinued his antisocial behavior, he developed a pronounced facial twitch, stammered embarrassingly, and became somewhat hypochondriacal.

With some delinquents, giving up a gang affiliation may mean surrendering their only human contacts. For example, Earl, a peripheral member of a gang, became so isolated and self-absorbed in the 8 months after he dropped the gang that serious concern was aroused about what had been accomplished in treatment. Since the boy was marginal, intellectually, emotionally, and socially, the gang's tolerance of him had been one of his few ties to reality. Treatment did not seem to be successful in replacing this with any stronger tie.

Such situations confront the therapist with the necessity of making very delicate decisions. How can he resolve such symptom-exchange complications? What issues must he carefully weigh in the balance? Assuming that the therapist can foresee eventualities like this, the course of action he follows cannot be prescribed automatically. It seems evident, however, that the therapist must measure his estimate of the amount of personal damage to the patient or client that might result against the potential social damage. In any case, I believe that in regard to delinquents the important criterion is the degree to which antisocial behavior is diminished.[3]

### *Some Treatment Problems*

From the point of view of treatment, the problem of values makes itself felt in two ways. On the one hand, the therapist must be able to sort out the confusions and contradictions of the differing standards facing each client. Unless he can do this, he may gravely impair the progress of treatment by misinterpreting the significance of the client's reactions. Thus, for example, he might mistakenly regard a young delinquent who maintains his hostility toward middle-class authoritative adults, including the therapist, as sick and therefore requiring intensive psychotherapy and fail to perceive his sound emotional and intellectual resources.

On the other hand, and probably of much greater significance in the dynamics of treatment, are the values explicitly or implicitly accepted by the therapist and reflected in his techniques. In this connection, it becomes essential that the therapist recognize the ways in which his value system may differ from the delinquent's because of differences in background, orientation, and life experiences.

Since many professional workers have middle-class orientations and living patterns, they tend to act in conscious or unconscious accordance with middle-class values. Indeed, even for the most competent professionals, class values that become merged with living styles achieve such potency as ideals and status symbols that looking at them with objectivity is extremely difficult. This suggests that often the therapist's middle-class values are built into the determination of treatment goals. While such goals may be appropriate for youngsters who come from a cultural background similar to the therapist's, they may not all be appropriate for a young person from a different socio-economic background.

However, in conceiving *long-range* goals the clash in values between the middle-class therapist and the delinquent of low socio-economic status may not create much real difficulty. After all, both the therapist and client generally accept the notion that therapy is intended to help the delinquent. Furthermore, since long-range goals are projected into the future, the delinquent tends not to become too concerned about them. Characteristically he is more

concerned with meeting immediate problems. Goal disparities become much more acute in relation to the short-range day by day objectives which develop in treatment.

A value problem arose for a therapist who was treating Connie, a physically matured, 17-year-old delinquent girl, when Connie announced that she was about to marry a sailor whom she had known only 2 weeks and who was scheduled to ship out soon. In the light of the girl's obvious charm and intelligence, and the shortness of the acquaintance, the step seemed tragic to the therapist, but from Connie's point of view it seemed to be the best way to escape from a near psychotic mother and a sadistic, sexually forward stepfather. Actually the marriage worked out well.

### *Examining Assumptions*

An examination of some traditional assumptions regarding treatment methods seems warranted. Time-honored practices in regard to confidentiality of information, recordkeeping, environmental manipulation, and sharing information with the client, for instance, may require modification in treating juvenile delinquents. In a New York agency which works with gangs, recognition of the need for some changes has resulted in the establishment of explicit criteria for guiding workers in reporting to the police such dangers as the use of narcotics, possession of firearms, and impending or actual gang battles. The need for immediate action in relation to a client being brought before the court might also require a prompt decision by the worker, without consultation with the client, on release of information to the authorities.

In the therapist are merged all of the value pressures forced upon the treatment relationship from the outside. If he is in an agency he not only brings to the therapeutic relationship his own set of values, but he also mediates the values of the agency's director, and board, and the community. For example, when a young delinquent acts out his conflicts aggressively in the agency's office or waiting room by loud yelling, banging away at an expensive typewriter, tinkering with the dictating machine, pocketing small objects, or disarranging pictures and shelves, the therapist's own attitude might be well attuned to the youngster's treatment needs, but the agency's administrator might not appreciate the therapeutic necessities and insist upon limitations which would circumscribe the therapeutic possibilities. In handling such a dilemma, the therapist had best be clear about the respective apportionments of permissiveness and of limit setting in treatment.

Agencies dealing with delinquents should be prepared for actional possibilities so that too much limit setting does not occur. The techniques developed by Redl and Wineman in an institution for seriously disturbed delinquents could be examined profitably in this regard.[4] The worker would also do well to anticipate acting out on the delinquent's part and, to the extent possible at the level of the therapeutic relationship, let the client know what is and what is not allowed before he actually does any damage. When Joe stole a dictating machine from the agency's office as a declaration of independence in the face of a deepening of his relationship with the therapist, the agency's administrator took a rather dim view of the therapist's assertion that progress was being made.

It seems clear that the view that the therapist must see himself functioning as a professional solely on behalf of his client needs some modification. For instance, if the therapist realizes that a client's strong destructive or self-destructive drives are fairly close to enactment, should he not let some other qualified persons, at school, in a recreational agency, or elsewhere, know so that preventive measures might be taken? Surely, a boy with overwhelming psychosexual difficulties could be steered away from such sexually stimulating situations as being left alone with a much younger girl or cast in a role certain to inflame his sexual fantasies. Certainly, departures from rigid confidentiality, even when strictly in the client's own interests, should be based on a prior understanding with the client, whenever possible. But when not possible, and the client or the community needs protection, what then? A reconceptualization of some formal ethical principles may be necessary, with the resulting hypotheses subjected to validation. The recently issued report of the National Social Welfare Assembly's ad hoc committee on confidentiality is a stride in this direction.[5] [See CHILDREN, September-October 1958, page 195.]

### *A Look at Techniques*

Orthodox treatment techniques, which flow from assumptions that may be valid for middle- and upper-class clients, seem also to require alteration to be effective for socially and economically depressed persons. Such techniques as remaining passive and not becoming involved in the client's day to day problems have been derived from these assumptions,



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as have such practices as keeping interviews to tight time limits and insisting that all interviews be held in the office. In working with a delinquent, such practices often result in loss of the client to treatment.

When Julian told his therapist that he was going out directly to steal an airplane, he would undoubtedly have either successfully flown away or killed himself trying if the therapist had not hastily trailed him to an airport and physically grappled with him beside the cockpit. Incidentally, this experience turned out to be the beginning of Julian's real involvement in treatment.

The delinquent most frequently is an especially resistant client, not merely because of inner motivations but also because of his immediately pressing concrete problems such as court appearance, physical danger, or the necessity to find a job. Such problems cannot await a detached, time-consuming, verbalistic approach. Moreover, talking to the therapist can to him seem too much like "squealing." Then too, the words of the therapist, unless artfully selected in language the delinquent understands, can sometimes increase his mistrust and confusion.

Another difficulty in treatment may arise because of a failure to realize that what middle-class, college-trained practitioners consider to be ordinary logic is not so perceived by many disadvantaged persons. This is not necessarily due to a lack of intelligence, but rather to a loss of interest when cause and effect relationships become complicated by numerous intervening variables. The threat of immediate demands is too great to permit such persons the luxury or anxiety of waiting for some future benefit.

Treatment of such clients is not an unalloyed, antiseptic process. The therapist working with delinquents invariably runs up against situations in which he must put himself out to a considerable degree. He must be prepared for a string of latenesses or broken appointments, calls from or to lawyers and probation or parole officers, appearances in court, visits to prison, efforts to help the client get a job or into a special school, and emergency calls at any hour.

Unfortunately, many trained therapists avoid working with adolescents, and particularly with delinquent adolescents. Low salaries and poor advancement possibilities in such work may be partly to blame, but so is a human tendency to prefer regularity, security, and comfort, which results in a sloughing off of the less desirable and less conforming (to treatment requirements) patient.

It is strange how often the same delinquent is regarded differently in different settings. Martin, who had been referred to an authoritative agency as a "psychopathic personality" requiring institutionalization, is a case in point. Further psychological and psychiatric examination indicated that the boy was reacting violently to a very difficult home situation and did not have anything like the degree of pathology indicated in the referring agency's diagnosis. He improved markedly in 3 months of intensive treatment in another agency. In the past 5 years he has committed no further delinquencies and is now a respected, self-supporting member of society.

In commenting upon the recruitment of staff to work with such delinquents and their families, Overton has said, "Often the workers with greater experience, whom it was most important to attract, saw this assignment as beneath their professional dignity. It was disappointing that they ran away. . . ."[6]

Experienced therapists seem to be ceding this area to the newcomers to treatment and consequently the less competent.

### *Clarifying Responsibility*

Because of the antisocial nature of the delinquent's behavior outside of the treatment setting, the therapist must at times face up to his own responsibility in regard to the possible consequences of such actions. What turns the balance to allow, or require, the therapist to call in other authorities—the probation officer, the parole office, or the police? What about the therapist's dilemma in handling aggressive behavior which occurs in his presence?

Suppose a delinquent in treatment steals the therapist's fountain pen, or a towering 6-foot teenager loudly threatens a much frailer therapist with physical abuse? Does the therapist have to take it? And if he does not, can the line of demarcation between punishing and setting limits be clearly distinguished?

These questions are not easy to answer. A great deal depends upon the role which the agency sees itself performing in the community. Certainly, however, a concern for other important matters such as an agency's public esteem can add heavy burdens to the therapist trying to treat the delinquent creatively.

Nevertheless, in the actual treatment relationship, the therapist must be in a position to perceive whether his own response is based upon his misinterpretation of the situation because of his own anxieties or whether the situation presents a real danger. If the

latter, then active intervention by the therapist, with the help of others, if needed, would seem necessary in instances in which the client himself, the therapist, the agency, or the community might be hurt. Failure to intervene may sometimes constitute an abdication of responsibility and lead to an inevitable failure in treatment.

When, as sometimes happens, the therapist receives a phone call that his delinquent client is getting drunk or threatening to get even with someone, the therapist ought to be able to move out toward the client at a moment's notice. In many cases treatment of the delinquent has to take place not only anywhere but also anytime. Therefore, agency treatment programming should be planned to assure continuous availability. Acting out, precipitated by the frequent crises in the delinquent's life, does not respect time schedules.

The question of what constitutes professional and citizen responsibility calls for much clarification—a task requiring considerable willingness, creativity, and mutuality on the part of all parties involved in the treatment of delinquents. Therapists must think this through not only individually and in their professional groups and agencies, but also with representatives of the bench, bar, law enforcement agencies, and the community at large.

The professional's conscience has probably had to wrestle more with descrying and allocating his responsibilities than with any other single problem. Yet any solution is apt to leave him feeling uneasy. To whom is a professional treatment person loyal and responsible? To his profession? His agency? The community? The client? Himself? He must, of course, be loyal and responsible to all, but the distribution and proportions of priorities need a basic spelling out.

How to do this is not easy to say. Clearly, however, each individual practitioner cannot avoid responsibility for his own actions. The sight of two or more experts testifying in contradiction to one another on the mental status of an offender can reflect not only on the validity of the data presented but also on the dignity of the adversaries and their professions. Such a situation, and others equally unfortunate, arise partly from disparities in role perception within the profession. More research on the role perception of therapists is needed. With more facts professional schools, community councils, and interdisciplinary organizations could join in developing sound guides for individual practitioners and agencies.

Similarly, agency responsibility requires clarification. An "agonizing reappraisal" of agency policies is called for to allow for more fluidities in treatment practice. The increasing effort in many places to "reach out" to the client is a move in the right direction. This sometimes requires teamwork, for one worker alone cannot always be effective in an acute crisis.

### *Agency Practices*

An example of the effectiveness of quick "team action" in a social agency is afforded in the case of 13-year-old Ellen, who ran away from home. If the agency supervisor had not talked to her father, the psychologist to her girl friend, and another agency worker to a relative—all at the same time—it might not have been possible for Ellen to go back home the next day as she did. The case of 14-year-old Joan affords another example. Joan's splenetic father would have needlessly taken her into court on a charge of ungovernability, if several agency workers had not teamed up to speak to father, daughter, and stepmother, and if one worker had not accompanied them home. Dealing instantly with these crises prevented them from further aggravating difficult family relationships.

Since the delinquent is almost always an "unwilling" client, it seems hard to justify, on a basis other than the agency's and the worker's convenience, a rigid insistence upon client voluntariness, office interviews exclusively and only in the daytime, tight time limits for appointments, and noninvolvement with the client's day to day affairs. These practices fit nicely into the middle-class pattern of living. The delinquent does not have such a pattern and if expected to follow one may rebel against the agency.

Many treatment agencies will not accept delinquents for treatment. Some even drop hitherto nondelinquent clients from their caseloads if they become delinquent while under treatment, although this is not now so common as in the past. Referring primarily to delinquents, Bloch and Flynn conclude that: "It is necessary to face the fact that the great majority of voluntary agencies dealing with family and children's problems have intake policies which turn away many of these children. . . ."[7] Public agencies cannot exercise such discretion.

Voluntary agencies, of course, have the right to define their function. Still the policies of many treatment agencies indicate why they are not more effective in meeting the area of social need exposed in delinquency. Their view of a client's repeated failure to appear for appointments as proof of

therapeutic inaccessibility is not convincing in the face of the experience of other agencies in working with "hard-to-reach" families.[8]

Clearly many value decisions affecting the treatment relationship lie beyond the therapist. As already mentioned, the agency might impose limitations upon the therapist, reflecting limitations imposed by the community. If the therapist's and agency's responsibility for safeguarding the community is accepted as a basic premise, some questions, with a reverse emphasis, might also properly be asked: How much will the community have to allow for in treatment? What tolerances should it provide? The answers can surely be defined more clearly, specifically, and scientifically.

Such specification requires considerable discussion of agency policy and practice on the basis of staff experience. It also requires carefully designed research. This might include: investigations of the types of antisocial reactions arising during the treatment process, correlating treatment dynamics with behavioral sequences; controlled assessment of the amount of damage to other persons and property wrought by delinquents who are undergoing treatment in comparison with their productivity and positive contributions to others; efforts to determine the effectiveness of different treatment approaches with different types of delinquents. We might then proceed to determine the implications of our findings for legislation, court procedures, police handling, and professional and citizen responsibility.

### *Value Similarities*

While the stress in this paper has been upon the effects of value conflict in treatment, it is equally important to understand the similarities of values between the delinquent and therapist.

The sociologist Kobrin has indicated that delinquents generally are affected by "a duality of conduct norms rather than by the dominance of either a conventional or a criminal culture,"[9] and maintains that no segment of our subculture places a positive value on delinquency per se. Cohen,[10] on the other hand, holds that the delinquent's subculture is essentially in opposition to the values of the dominant middle class.

The therapist does not need to resolve these differences in theory in order to recognize points not only where his delinquent client's values differ from those of the dominant culture, but also where they are the same, as in loyalty to one's family and friends, the need to work for a living, and the right to fulfill oneself. Such similarities in values afford tremendous support for the furtherance of treatment objectives since, in a sense, they provide a common operating base between therapist and client.

Unfortunately delinquents often share some or many of the values of the therapist, yet act in ways which are in contradiction to them. Their value systems, including those values which are directly opposed to the community's, seem to be poorly integrated and unstable, and hence they are confused and conflicted about how to behave.

One of the objectives of the therapist is to help the delinquent hang on to, and indeed augment, those aspects of social conformity and self-control which can be used in keeping him from getting into trouble. I believe that this can be accomplished while helping the individual to fulfill his rights to self-expression and self-realization within the framework of a democratic conception of living.[11]

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[1] Glueck, Sheldon and Eleanor: Unraveling juvenile delinquency. Commonwealth Fund, New York, 1950.

[2] Davis, Allison: Social class differences upon learning. Harvard University Press, Cambridge, 1952.

[3] Chwast, Jacob: Realistic goal-setting in treating delinquents. *Journal of the Association for Psychiatric Treatment of Offenders*, September 1958.

[4] Redl, Fritz; Wineman, David: Controls from within. Free Press, Glencoe, Ill., 1951.

[5] National Social Welfare Assembly, New York: Confidentiality in social service to individuals. 1958.

[6] Overton, Alice: Aggressive casework. *In* Reaching the unreached. New York City Youth Board, New York, 1952. (Revised 1957.)

[7] Bloch, Herbert A.; Flynn, Frank T.: Delinquency: the juvenile offender in America today. Random House, New York, 1956.

[8] New York City Youth Board, New York: Reaching the unreached. 1952. (Revised 1957.)

[9] Kobrin, Solomon: The conflict in values in delinquency areas. *American Sociological Review*, October 1951.

[10] Cohen, Albert K.: Delinquent boys. Free Press, Glencoe, Ill., 1955.

[11] Chwast, Jacob: The significance of control in the treatment of the antisocial person. *Archives of Criminal Psychodynamics*, Vol. 2, No. 4, Fall 1957.

# INTERPROFESSIONAL TEAMWORK TO SAFEGUARD ADOPTIONS

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THE FACT that the medical, legal, and social-work professions all have functions in the adoption process is gaining recognition.[1] However, a clearer understanding of the specific roles of each and how they mesh together is necessary on the part of the professions themselves as well as the public at large to achieve the kind of coordinated effort that can give the best protection to children against unwise adoptive placement. While in each of these professions many members accept a responsibility in the adoption process, there are in each some members who in their concern tend to lose perspective about their own professional competence and try to play all three roles. Aware of this and other problems, the Children's Bureau in 1955 sponsored a meeting of all the professions concerned with adoption, including medical, legal, social work, nursing, and the clergy, to discuss ways of promoting safeguards.

The Bureau has followed this up in the past two years with a series of meetings held separately with physicians, social workers, and lawyers in an effort to arrive at clear definitions of the role of each in adoption.[2]

The social workers' meeting included social workers from public and private children's agencies, maternity homes, councils of social agencies, and hospital social-service departments. The physicians' meeting included general practitioners, obstetricians, pediatricians, internists, psychiatrists, public-health administrators, and hospital administrators. The attorneys' meeting included attorneys engaged in private practice, law-school professors, and consultants to public and voluntary social agencies. Out of these meetings and similar meetings sponsored by professional organizations, some general principles have evolved. They emphasize each profession's responsibility for performing those special functions which demand its particular skills.

### *To Each His Role*

The following points were made at these meetings:

**The Physician.** The medical needs of the unmarried mother include confirmation of pregnancy, prepartal care, confinement, and postpartal care. Because of the general confidence in physicians, the doctor is likely to be the first person to learn about her suspicion of pregnancy, sometimes only after she has long denied her fears. A good doctor-patient relationship takes on special importance when the patient is a troubled, fearful, unmarried pregnant woman or adolescent girl who does not know where to turn or how she will manage her future life or that of her baby. Because the effectiveness of medical care for troubled patients depends on meeting many other than medical needs, the physician should refer unmarried mothers to a social agency for help in planning.

Delivery, examination, and treatment of the child are of course physicians' functions. Only a doctor can evaluate and provide treatment, if needed, for the child's physical condition. The physician's special medical knowledge and skill are also needed in judging the development of the child.

A physician's services are also needed for assessing

the health and general physical ability of adoptive applicants to accept and care for a child, for studying their physical condition in connection with the cause of their childlessness, and for making recommendations in regard to treatment for infertility.

**The Attorney.** The attorney is needed for performing all legal services in adoption in respect to or on behalf of the natural parents, the child, or the adoptive applicants. The unmarried mother, the married woman whose husband is not the father of her child, the married couple who cannot adequately assume responsibility for a child, all need to know their rights and legal responsibilities when they are considering giving up their child for adoption. They should also know about the rights and legal status of the child, the specific information carried on a birth certificate, what is involved in paternity proceedings, laws regarding legitimation, and the legal responsibilities of the child's father. The natural parents also need information of a legal nature regarding legal surrender of a child, procedures for judicial termination of the legal parental relationship, and the effect of such a severance of rights on any future plan for the child.

Before a child is placed for adoption an attorney is needed to ascertain the legal status of his parents so that, if the mother is married or divorced, her husband's rights can be fully considered and his consent secured as legally required. An attorney's services are also needed to protect the rights of the child to inherit and to resolve any legal impediments that could place his inheritance rights in jeopardy at the time of adoption or in the future.

The attorney is needed to prepare legal documents required in handling the adoptive couple's petition to adopt the child, and to inform the couple of their legal rights and responsibilities in connection with the adoption. The skill of the attorney is also necessary in handling the legal steps in the adoption process in a way that will protect the decree from later attack insofar as possible.

The attorney's client may be the natural parent or the prospective adoptive couple. In either instance he should refer the client to a social agency for appropriate services.

**The Social Worker.** The social worker in the adoption process works through an organized social agency authorized by the State to make adoption placements or provide services to unmarried mothers. A person trained in this profession is needed for helping an unmarried mother to deal with her emotional turmoil and arrive at an unequivocal decision as to whether to keep or release her baby, for determining the suitability of the adoptive applicants to care for a child, for selecting the home which seems best suited for the particular child, and for making the actual adoptive placement.

The social worker's skills are important in helping an unmarried mother to build or restore self-esteem, to use her potentials, and to achieve a greater understanding of herself; and, in order to give the child the best opportunity for healthy development, in helping the mother make her decision regarding herself and her child as early as possible.

The social worker's knowledge of the psychological needs of all children and her skill in determining the needs of the particular child are necessary in deciding on the kind of home in which the child will flourish. Social-work training in assessing the personal qualities of people and weighing their flexibility, stability, and capacity to love and care for children is also necessary in the consideration of the suitability of a prospective adoptive home for any child and for a specific child.

The agencies providing this social casework service must develop or call upon resources for medical care, psychiatric consultation or treatment, financial aid, shelter for unmarried mothers, temporary and potential adoptive homes for children, and legal services in helping the natural parents, the child, and adoptive parents.

### *Coordination of Skills*

As important as the medical, legal, and social-work professions are in the adoption process individually, they are greatly handicapped unless they are understood and accepted by each other and unless their work is coordinated.

The physician may be confronted by an unmarried pregnant girl who cannot resolve her quandary about where to live, or whether to tell her parents, or who may be in a state of dangerous despair. The social agency may accept responsibility for a child whose parents have deserted, and whose physical growth has been impeded by neglect. An attorney may be asked for legal counsel and advice concerning the responsibilities involved in adoption by a couple who are in disagreement about a desire to adopt a child.

Each profession provides its special skill to each of these individuals, and yet unless the skills of the other professions are called upon the needs will not be met.

Because the social agency must have all these skills readily available, either on its own staff or within the community, social agencies are in a key position to bring about greater understanding among individual members of each profession of the contributions each has to make to the adoption process. If this understanding is to be widespread among the professions, however, representatives of the local medical and bar associations and of social agencies need to come together for discussion. In a number of communities representatives of the local social planning council have taken the initiative in achieving this.

A hospital administrator is also in a key position to effect understanding among the doctors, nurses, and social workers of the protections and services needed by the unmarried mother and her child. In some hospitals procedures have been worked out to provide such protections.[3] They include provision for referrals to the social-service department or agencies in the community, legal consultation regarding placement and licensing laws and requirements for temporary and adoptive homes, and designation of placement responsibility to the social-work profession. Such development of clear-cut policies and procedures allows each staff member to concentrate on his own responsibility in caring for the patient and her child.

An encouraging sign for improved understanding is the increasing number of statewide gatherings of the professions to discuss the adoption process. A conference of this kind, the Rocky Mountain Regional Conference on Adoptions held in Estes Park, Colo., a few years ago, was sponsored jointly by the Colorado Medical School, Colorado State Department of Public Health, Colorado State Department of Public Welfare, and the Children's Bureau and was attended by physicians, attorneys, judges, nurses, psychologists, clergymen, and social workers from nine States.[4] A physican was chairman both of the planning committee and conference. Many of the participants subsequently became active in efforts to increase understanding in their communities of what is involved in the adoption process. They reported on the meeting of the local or State professional organizations, wrote articles for professional publications, and stimulated interprofessional meetings.

A similar conference on a statewide basis, held in Iowa City, Iowa, in May 1958, was sponsored by the State University of Iowa, including the College of Medicine, College of Law, School of Social Work, Child Welfare Research Station, and Graduate Program in Hospital Administration, in cooperation with the maternal and child health division of the State Department of Health, the division of child welfare of the State Department of Social Welfare, and the Iowa Association of Child Placing Agencies and Institutions.

Last year the 28th Ross Pediatric Research Conference brought nationally prominent doctors, social workers, and lawyers together at Tulane University for 3 days to discuss "The Child and the Law," focusing a large portion of their attention on the legal aspects of adoption.

The Massachusetts Academy of Pediatrics at its recent annual meeting held a session with the subcommittee on interprofessional relationships of the United Community Services committee on unmarried mothers. A pediatrician, an attorney, and a social worker participated in the panel describing the role of each profession in adoption.

As a result of similar joint discussions among professional groups, State medical societies in North Carolina, Ohio, and Utah have approved resolutions that in essence discourage participation of their members in direct placement of children for adoption and recommend use of authorized social agencies for this purpose. The Cleveland Medical Society and the Cleveland Bar Association have approved similar resolutions.

### *Results of Teamwork*

Cooperation among the professions is especially important in order to achieve improved legislation. Legislators and the public must know about the safeguards the laws should provide. Professional teamwork in interpretation is a prerequisite to effective legislative action.

Determination of what services are needed and what gaps exist in a community are special responsibilities of board and staff of social agencies, councils of social agencies, and State departments of public welfare. However, responsibility for taking steps to meet the gaps in adoption services falls on all the professions concerned and is best assumed by joint action. If there are insufficient medical services for unmarried mothers in a State or community, for example, medical and social-work groups can plan together to increase them. Such teamwork has proved to be effective in Connecticut, where the State Department of Health works with social agencies in developing a plan for providing services of all kinds to unmarried mothers.[5]

In Wisconsin and in North Carolina teamwork among the professions has been followed by a decrease in unprotected placements for adoption. In Illinois, social workers, judges, and attorneys, aware that the State adoption and placement laws do not give full protection to children or their parents, are working with a committee from the State bar association to draft bills for introduction into the legislature.

The Greater Hartford Community Council in Connecticut established an interdisciplinary adoption committee in 1955 to bring about better understanding among doctors, lawyers, clergymen, and social workers. In 1957 the committee recommended that placement of children with nonrelatives for adoption be limited to authorized child-placing agencies, and urged that the law be changed to require a social study to be made. The report was accepted by a majority vote. In July 1958 a new law became effective requiring that, except for adoptions by relatives, an adoption petition may not be filed unless the child was placed with the petitioners by a licensed agency.

### *Increasing Knowledge*

Granted that graduate professional schools of all types are faced with a serious problem in selecting curriculum content from the vast amount of knowledge in their own fields, still it seems necessary for medical, law, and social-work schools to impart information on adoption so that their graduates will go into practice aware of the necessity of working cooperatively with other professions.

Medical schools are stressing the need to see a child both as a person and as a member of a family. As part of this approach, some medical schools call on social workers to give their students information about social needs and services including the special problems that a physician sometimes faces in practice in regard to adoption. Such efforts might well include content regarding the social and emotional problems of unmarried mothers and their children, resources offered to them by communities, laws of the State pertaining to placement of children for adoption, and other information physician needs to keep in mind when confronted with an unmarried mother or a family seeking a child to adopt.

The application of various kinds of new knowledge about children's needs can help to improve adoption practice. For example, the studies of the psychiatrist John Bowlby and others on the ill effects of separation of a young child from his mother-figure have deeply impressed adoption agencies with the importance to the child of early adoption. The legal profession, through an analysis of laws related to adoption, has found ways in which legislation can offer greater safeguards to natural parents. Dissemination of information about new discoveries that can affect adoption and about problems that need to be solved is a responsibility of all professions.

There is a beginning interest in learning through research how effective various kinds of adoptive placements have been. For example, in Florida a study is under way of children who were placed for adoption independently approximately ten years ago [see CHILDREN, May–June 1956, page 115], and in Chicago the Elizabeth McCormick Memorial Fund has been considering the question of how to make more significant studies of adoption outcomes [See CHILDREN, January–February 1959, page 35].

In working together to improve adoption practices the professions are coming to realize that their combined knowledge does not yet include all that needs to be known to protect fully the children and adults involved in the adoption process, and that each has a responsibility for seeking on its own and with other professions the missing links in such knowledge.

Effective cooperative effort in the adoption process requires conviction as to the importance of providing protections to parents who might be considering giving up a child for adoption, to the child whose opportunities in life are determined by his adoptive placement, and to the couple that wants a child and can offer him love and security.

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[1] U.S. Department of Health, Education, and Welfare, Children's Bureau: Protecting children in adoption; report of a conference. Children's Bureau Publication No. 354. 1955.

[2] ———: The physician's part in adoption; The social worker's part in adoption. Children's Bureau folders nos. 44 and 45. 1958. The attorney's part in adoption. CB folder no. 47. 1959.

[3] Boole, Lucille: The hospital and unmarried mothers. *Children*, November–December 1956.

[4] Colorado State Departments of Public Health and Public Welfare: Professions exchange ideas about adoptions. Denver, 1957.

[5] Curtis, Hester B.; deRonge, Alberta: Medical and social care for unmarried mothers. *Children*, September–October 1957.

*An essay-review . . .*

# ARE PARENTS CHANGING?

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THE STUDY of child-rearing practices has been intensified by psychologists, anthropologists, and sociologists in the past decade. This demonstrates a growing awareness of need for more empirical data about the development of children. We assume, and apparently correctly, that knowledge of the child's experiences during the course of his development is important for the understanding of adult behavior, and so also for increasing our knowledge of the prerequisites of mental health. Moreover, examination of child-rearing practices is important as a basis for comprehending cultural continuity and change, for culture is transmitted through child-rearing practices that aim to develop personalities compatible with cultural requirements.

Many observers of the social scene have commented on the social and psychological effects of changes occurring in our society: the movement toward conformity and materialism; the emotional quietism in educational circles; the decentralization of large urban areas; the mounting levels of production and consumption; and the increasing speed and uncertainties of the space age. There is need, however, to get beneath the surface and begin empirical validation of these assumed changes and to assess the intensity of their impact, particularly since they can affect our national life and even survival. Of course, the segments of a society as complex and diverse as ours change in varying degrees and in varying ways. The problem for the social scientist is to develop concepts and methods by which the broader changes can be examined in relation to their impact on children. One aspect of this larger problem is the relationship between one's occupational situation and his value system as reflected in his child-rearing practices.

Daniel R. Miller and Guy E. Swanson in their recent book "The Changing American Parent"[1] add new dimensions for the study of child-rearing practices by presenting the concepts of "individuated entrepreneurial" and "welfare bureaucratic" personalities—both of which reflect the individual's type of occupational setting. Heretofore, nonsociologists have tended to adopt many sociological concepts, including social class and social structure, often without closely examining their psychological significance. In this book, however, a psychologist (Miller) and a sociologist (Swanson) have integrated their combined knowledge and points of view toward a common problem: the study of child-rearing practices in a large urban community. The book is significant as an attempt to investigate the role of the economic social structure in child rearing.

### *Occupational Settings*

The authors apply the terms "individuated entrepreneurial" and "welfare bureaucratic" to situations in which individuals perform their tasks—their places of occupation. These they call the "integration setting" since they denote the way an individual becomes integrated with others.

The "entrepreneurial" refers to integration settings having the following features: They are small in size, have high division of labor, possess relatively small capital, and provide mobility and income through risk taking. Such integration settings, according to the authors, tend to isolate people from one another and from the controlling influence of the

broader cultural norms. They hypothesize that in families where the primary occupational setting is entrepreneurial the parents will encourage their children to be highly rational, to exercise great self-control, to be self-reliant, and to manipulate their environment.

The term "welfare bureaucratic," on the other hand, refers to large organizations which employ many different kinds of specialists, have substantial capital, and pay salaries or wages. Upward mobility in the "welfare bureaucratic" setting occurs through specialized training for particular positions rather than through success in taking risks. This type of setting offers the individual considerable support in meeting personal crises, as well as considerable security in regard to continuity of employment and income. The authors hypothesize that the children of persons employed in such settings will be encouraged to be accommodative, to allow their impulses some spontaneous expression, and to seek direction from organizations in which they participate.

Whether or not the authors have oversimplified these settings or whether such clear distinctions exist are open questions. The interesting point is that the authors have tackled a traditional anthropological problem, to test whether the value system held by the parents—which, they hypothesize, is reflected by the father's occupational setting—leads to, or is related to, specific child-rearing practices. Thus, a kind of culture continuity is envisaged, the children being reared to adapt to the kinds of settings their parents value.

The validity of such hypothesizing has yet to be fully demonstrated, for the study's findings are not striking. Part of the failure to obtain the kinds of findings expected may arise from the limited length of the interviews and of the limited scope of the study; for the authors have tended to focus on mothers, who, in the families studied, are not direct participants in either type of occupational setting. Studies of this nature, bringing in both parents, are needed.

The intent of this discussion, however, is not to focus on the methodological limitations, of which the authors themselves are aware, or on their methodological sophistication which becomes self-evident in many sections of the volume. It is to note the contribution of their orientation to study of the broad social scene and examine some of the implications.

As the authors in this volume tend to suggest, a "welfare bureaucratic" occupational setting, where certain kinds of individualism are not encouraged, frustrates some persons to the point of unhappiness. On the other hand, it makes others feel relatively comfortable and secure. The big question that arises in connection with the effects of this type of setting on the person's child-rearing practices is whether or not he is attracted to it because of the kind of goals, values, and attitudes he has, or merely because of the limited choices available or the attractiveness of the salary. A person is faced with potential conflict if he does not really want to work in this type of setting and is seduced into it by its security-giving features. In pointing up these kinds of questions, the authors pose important problems for further research. The fact that some of the study's findings reflect differences between the entrepreneurial and bureaucratic groups suggests the value of delving further into these relationships.

### *The Study*

The authors interviewed 582 mothers in the Greater Detroit area. They classified them into entrepreneurial and bureaucratic groups, with further breakdowns within each group into upper-middle and lower-middle class.

They have found some significant differences between the entrepreneurial and the bureaucratic mothers: for example, among the lower-middle-class groups, entrepreneurial mothers are more likely than bureaucratic mothers to begin urinary training before the baby is 11 months old. Similarly, a difference exists between the two lower-middle-class groups in the use of symbolic punishments—blame to induce feelings of guilt rather than direct action such as spanking. These practices are tests of the author's hypotheses: that early training is related to such characteristics as self-reliance and independence, and, consequently, that those individuals who are so oriented act accordingly, but the differences between entrepreneurial and bureaucratic groups do not appear in the upper-middle-class families. The data tend to support the theory that entrepreneurial mothers tend to place more emphasis on an active manipulative approach toward life than bureaucratic ones.

The authors report little success in forecasting differences between the upper and lower classes *within* the entrepreneurial group. However, when they compare the entrepreneurial and bureaucratic groups and control for religion—Protestant and Roman Catholic—a number of their findings are in

the anticipated direction, especially when they compare the two religious groups of one entrepreneurial group, holding social class constant. An illustration of the findings is that Protestants are more likely than Catholics to use symbolic rewards and punishments. The same results are not found with the bureaucratic group.

Bringing in religion as a variable is in itself a considerable contribution to the study of child-rearing practices. However, this reviewer was surprised to note that Protestants are lumped into a single group, since they vary so in religious ideology. Control for ethnicity is suggested, but not sufficient for the purpose.

Thus, in attempting to analyze together the effects of religion, integration setting, and social class, the authors move away from the simplicity of the criteria generally used in child-development research toward a consideration of the large variety of criteria that should be recognized and controlled. They are completely aware of the complexity of what they are studying.

Near the end of the book they speculate about the relation of family personality to bureaucracy; the effects of increasing urbanization on the family; the questions of companionship in the entrepreneurial and bureaucratic families; and what persons in these groups tend to expect of each other and of themselves in a society where occupation and income are measurements of status.

Although the authors say their concern is with the *changing* American parent, many questions as to how and to what degree parents have changed are left unanswered. This is at least partly due to the fact that little research of this nature has been done in the past. However, the authors do note some changes reflecting societal changes in requirements and expectations, and present an interesting historical analysis of shifts in child-rearing orientation and philosophy.

### *Research Stimulus*

This book, then, offers a variety of suggestions for future research. The limitations in the extent and depth of the undertaking should not detract from its value as a stimulus to future research and conceptualization.

One can argue that the assumption that the occupational setting is of such paramount value in relation to child rearing is highly inferential. There is also the question: Does the mother necessarily reflect the values held by her husband? Some studies have indicated that there is no correlation between mothers' and fathers' child-rearing practices. The authors themselves give a schema suggesting further areas of detailed thinking in regard to the relationship between a person's occupational setting and value system.

One could go on endlessly posing questions for further research as a result of reading this book. However, the questions already raised indicate that some caution should be employed in moving "whole hog" in the direction the authors suggest. Nevertheless, exploratory work of this kind offers new vistas for more inclusive types of conceptual schemes for research workers, helping us to move away from the social class studies of the past. A need for this has been made apparent by Littman and his associates [2] who have reported that a comparison of three studies of child-rearing differences in as many communities pointed "quite clearly to the absence of any general or profound differences in socialization practices as a function of social class."

However, it is also important to keep in mind that studies done, as was that of Miller and Swanson, on the basis of survey techniques—in which the children themselves are not observed or studied—raise considerable questions as to the significance of the results. It is easy to lose sight of the fact that the basic purpose of studying child-rearing practices is to answer the question: What differences, if any, do specific practices make in the child's current and long-term behavior?

Studying the parents as such is of interest and may contribute to an understanding of our broader society; but the "proof of the pudding" lies in determining whether or not these differences are of real import. Thus, the next step is to study children in relation to the differences observed among their parents. In other words, we still must validate the basic hypothesis that differences in child-rearing practices among any kinds of groups result in differences in their offspring.

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[1] Miller, Daniel R.; Swanson, Guy E.: The changing American parent; a study in the Detroit area. John Wiley & Sons, New York, 1958. $6.50. 302 pp.

[2] Littman, Richard A., et al.: Social class differences in child rearing: a third community for comparison with Chicago and Newton. *American Sociological Review*, December 1957.

# A NEW LOOK AT HOMEMAKER SERVICES

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SOCIAL AND HEALTH AGENCIES, like business organizations, need to take inventory periodically—to take stock of what they now have as a step in planning for the present and the future. Such an evaluation may confirm belief in the accustomed way of doing things or it may bring a new look leading to developments in an entirely different direction or to a realignment of priorities.

Such a new look was one goal of a group of approximately 300 people who met in Chicago recently. They were there attending the National Conference on Homemaker Services, whose purpose was to stimulate the development of homemaker services throughout the United States. The 2-day meeting was sponsored by 26 national voluntary welfare and health agencies and 8 units of the Department of Health, Education, and Welfare. The conferees represented many organizations—National, State, and local; public and voluntary; welfare and health. They included doctors, nurses, social workers, therapists, home economists; leaders from industry, labor, health insurance groups, and communities.

The participants made several outstanding suggestions on which there seemed to be general agreement. They expressed the belief that in community planning priority should be given to services which help people to remain in their own homes, providing it is suitable for them to do so—families with children, the chronically ill, and the aged.

They expressed repeatedly another concept: that homemaker services should be available to all people in the community who need them, regardless of income or geographic location—payment to be made in accordance with financial status. If this concept is carried out, provisions for homemaker service must be greatly expanded. Therefore, the conferees suggested that National, State, and local agencies must work together and that there must be teamwork between the health and welfare fields.

Closely allied to this idea of community-wide availability was the conviction expressed that voluntary agencies alone could not provide sufficient homemaker services to meet the increasing demands arising out of conditions due to death, illness, incapacity, infirmity of age, or other social, economic, and emotional difficulties. Therefore, the conferees suggested that governmental agencies at all levels should make provision for homemaker services, directly or by payment to other agencies, for those unable to purchase services for themselves. Public agencies, it was maintained, should provide a broad service to meet all types of problems and should be able to serve all income groups when such service does not duplicate an existing service.

### *Structure*

Only three written papers were presented at the conference. One by Katherine B. Oettinger, Chief of the Children's Bureau, on the needs of individuals and families for homemaker services, spelled out the reasons for the conference. One by Dr. David E. Price, Assistant Surgeon General of the Public Health Service, described the "inextricable partnership of health change and social change." And in another, Sol Morton Isaac, president of the Ohio Citizens Council for Health and Welfare and past president of the Family Service Association of America, discussed community responsibility for facing the demand for services to help people live at home.

The greater part of the time was given to 19 discussion groups planned for approximately 20 people each. Previous to the meetings each participant had received five pamphlets prepared by the Department of Health, Education, and Welfare. These included 12 descriptive statements of agency programs;[1] preconference study group reports;[2] a report of a nationwide study of homemaker services;[3] a directory of such services;[4] and a descriptive leaflet for popular consumption.[5]

Each group decided how the allotted time would be used and at the end recorders turned in their reports.

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A report of the 1959 National Conference on Homemaker Services, Chicago.

One occurrence at the National Conference on Homemaker Services not alluded to by the author in the accompanying article was the presentation to her of a plaque in recognition of her own part in the stimulation and development of homemaker services. In making the presentation on behalf of the Conference, Mrs. Katherine B. Oettinger, Chief of the Children's Bureau, referred to the meeting as "a pinnacle in her steady effort for homemaker service" and told of Miss Morlock's work in organizing the first conference on "visiting housekeeping services" called by the Bureau in 1937, in helping to found the National Committee on Homemaker Service, and in "journeying over the land" for nearly a quarter of a century "urging, encouraging, prodding, seeking to improve" homemaker services.

Miss Morlock, who retired from the Bureau's staff on March 10, was similarly honored in New York in January for her work in behalf of unmarried mothers, at a dinner given her by the National Association on Services to Unmarried Parents, an organization she also helped to found.

These were later summarized to the entire conference by the five section chairmen. Although a particular discussion group might voice agreement on a certain point or even be sufficiently formal to register a vote on a recommendation, no action was taken by the conference as a whole. Because this method was followed, this article can only present some highlights of what transpired.

### *Recurring Ideas*

A reading of the recorders' reports and the speeches reveals many recurring ideas. Some of these are:

**More homemaker service for the aged.** In urging increasing service to the aged, the groups suggested that when a community starts homemaker service it should include plans for the elderly as well as for families with children. They also emphasized the importance of a close relationship between social and health services because of the frequency of physical and mental impairment among the elderly.

It was repeatedly pointed out that many older people who might otherwise not be able to remain in their own homes can do so if they have the regular help of a homemaker for only a few hours a week; that for them this means a happier, more independent life, and that for the community it is often less costly than caring for the person full-time in an institution.

**Determining length of service by need.** As was to be expected from this multidisciplinary group, with many of the leaders in the health field joining forces for the first time with social workers, the health aspects of conditions creating the need for homemaker services received considerable emphasis. Dr. Price pointed out that the Public Health Service's survey of homemaker services [3] revealed that 93 percent of the homemaker service given was in situations where there were health problems, in many instances chronic illness requiring long-time homemaker service. The conclusion follows, as one group noted, that the length and amount of time homemaker service is given to people should be determined by their needs, periodically reevaluated.

**The training of homemakers.** This conference gave particular attention to the importance of training homemakers, the content of training, and how to accomplish it. The conferees pointed to the need to define first what the job is in order to know what homemakers should be trained to do, and then to gear the training to the homemakers' level of understanding.

**Interpretation.** There was general agreement on the importance of interpretation, both of existing services and of the need to provide further services. Those mentioned as especially needing to know about homemaker service were doctors, nurses, and hospital personnel; representatives of labor and industry; ministers, teachers, service organizations, and community health and welfare agencies.

It was suggested that various media be used with imagination to put the story across, and that this task should not prove too difficult since homemaker service is visible, tangible, and a concept easy to grasp.

Interest in developing homemaker services, it was suggested, may be created by one or two people, or by a group of people. Frequently they will need immediate consultation in planning, perhaps from the community health and welfare council or the State department of welfare or health or a local agency. A group representing various interests in such a service can be helpful in assessing need and setting up steps for developing and nurturing a program.

### *New Emphases*

Other concepts emphasized had a touch of newness or strength not apparent at earlier conferences. There was an emphasis on flexibility of program; on the importance of keeping the focus on the needs of people; on using the service imaginatively; and on

the multiplicity of ways in which a good homemaker service can strengthen the community.

Pleas were made for extending homemaker services not only geographically, but also quantitatively and qualitatively and for making them available more quickly in a time of need.

**Prevention.** Although homemaker service has frequently been referred to as a preventive service, there seemed to be more conviction about this than in the past. The participants asked for a broader coverage to prevent breakup and deterioration of the family. They wanted this service not simply for the underprivileged, lower income group with multiple problems, but for the so-called normal family who might never have been known to a community agency had not adversity hit. It was pointed out that among other advantages an agency homemaker service offers certain protections such as an ability to adjust to the individual's or family's needs; to guarantee quality, reliability, and continuity of service; objectivity, knowledge, and skill in evaluating the need for the service and in providing it; supportive help and sharing of responsibility both to the homemaker and family; removal of direct financial relationship between the family and homemaker; helping the family to develop and use its own resources.

The participants also expressed conviction in another function of homemaker service closely allied to its preventive role—that it has much to offer to parents who need and want help in providing better care to their children and their home. These are often young parents whose intentions are good but whose own background is such that they have not known the better things of life, and hence their care of their children and their homes is so substandard that the community becomes disturbed about it. Help from a motherly, well-qualified homemaker, working with a caseworker, can change the pattern of life both for those immediately involved and for future generations. And it can save the community much in time, energy, and dollars and cents.

**Industry and labor.** A new note was also struck in the emphasis on the importance of homemaker service to industry and labor. Such a service, it was pointed out, conserves manpower and cuts down insurance and production costs by alleviating anxiety of the workers, enabling dependents to secure medical care, and helping to maintain family units during periods of threatened disruption.

The group discussing this subject recommended that the need for homemaker service for industrial personnel be assessed so that management and labor may recognize the desirability of supporting such a service. It also suggested that this type of service be considered as part of industrial medical care plans, urging vigorous interpretation of this approach.

Another new proposal was that voluntary health insurance should include coverage of the cost of homemaker service as a part of medical care. This would require the identifying of the insurable service, its incidence, duration, and cost.

### *Controversial Issues*

Other questions were thrashed out but not resolved.

**Auspices.** One of these relates to the auspices under which homemaker service can be administered. The participants seemed generally to accept the concept of homemaker services as a community service, an integral part of the health and welfare program, financed by voluntary or public funds with the family or individual paying in keeping with his ability; but they expressed different viewpoints as to its specific auspices.

One group reported as follows:

"1. The auspices of a homemaker services program may be differential and need not be a social agency.

"2. However, because the professional training of the social worker gives him the broadest base for understanding family life, he is better able to administer a homemaker services program than any other professional person. This is desirable and will provide optimal service, although it may not be realistic to say social work administration is necessary."

Another group expressed the opinion that experience is too limited for categorical statements to be made on the relative values of each type of agency sponsorship, and recommended that "primary emphasis be placed on each community evolving its own approaches."

Still another group reported:

". . . establishment of a homemaker service might be considered as furthering the programs of existing agencies—which would be as broad as those agencies' coverage. If in a particular locality the need manifests itself for the establishment of a new agency providing homemaker service as its sole responsibility, this could be set up as an independent agency accepting direct applications or giving serv-

ice to public or private agencies not having a homemaker program of their own or one adequate to meet their needs. The solution of the latter problem (insufficient service) might be the responsibility of a community council of welfare and health agencies."

Agreeing that auspices for maintaining services would vary, this group maintained that what was important was "to consider the needs of the people rather than the organization."

Another group recommended research "to determine under what circumstances it is preferable to have a specialized agency providing recruitment and training of homemakers and service to a total community (from which various other agencies may, if they desire, purchase service) and when it is better to have the individual agency within the community assume responsibility for its own recruitment, training, and service." To provide the basis for such research it suggested that an increasing variety of agencies, both public and voluntary, provide homemaker service on an experimental basis.

Still another group commented: "Regardless of whether a homemaker service is based in a social or in a health agency, appropriate health and social services should be available when needed."

Discussing the question of appropriate auspices in his address, Mr. Isaac pointed out that it requires the facing of difficult decisions. If each agency which regards homemaker service as useful to its objectives creates its own service to meet its special requirements, the results in duplication of effort, unnecessary expense, and lack of coordination will be the kind of fragmentation that weakens community support for and understanding of the service, he warned. Asserting that "centralization appears to be considerably more effective" he nevertheless pointed to problems of determining standards, sources of support, and eligibility for service that have to be faced in the establishment of a centralized service and urged the resolution of these issues in each community through its council of social agencies.

**Social casework.** One of the most controversial issues in regard to homemaker services involves the use of social casework—what it is, who needs it, and whether it is an essential part of a homemaker program. This was reflected in the conference discussions.

On the one hand were those who pointed out that many people who need a homemaker have economic, social, and emotional problems in addition to the health difficulties which precipitate the request for homemaker service, and that the purpose of the service is to maintain and strengthen family ties and relationships and to help the individual to be as self-sustaining as possible. They also pointed out that homemaker services is a community service involving accountability for the spending of voluntary and public funds. Maintaining that casework should be defined broadly as "helping people in trouble" and its use adapted to the particular situation in the family, they argued that the giving of homemaker service involves the casework process in helping the individual determine whether this type of service is the best plan and if so, what will be required of the homemaker, the length of time she will be needed, and the fee to be paid. They also maintained that the selection, training, and supervision of the homemaker involve casework knowledge and skills. If casework isn't a part of the program, they asked, isn't the service something other than homemaker service?

**A homemaker with two of the hundreds of children she has cared for in their own homes in time of crisis in the family. She has been a part of the homemaker service of the Catholic Charities in Cincinnati for 16 years.**

These have been and are now the concepts accepted by most agencies providing homemaker service up to the present time. Their experience has led them to believe that casework is an essential element in homemaker service, particularly at intake. This point of view is shared by many health agencies.

On the other hand, there were those who raised questions as to the extent to which casework is es-

sential in providing homemaker services to self-sustaining "normal" families and individuals who need and are able to pay for it. There was also discussion of whether or not members of other professions, such as the public health nurse, were equipped by their training to carry some of these responsibilities.

One group suggested that the issue concerning the use of casework in homemaker service might best be clarified by studies of homemaker services under a variety of auspices and using a variety of personnel, such studies to be carried out by a multidisciplinary team. These studies, it was suggested, would also throw light on the standards necessary to make the service effective. The importance of establishing standards of service was emphasized throughout the conference, in formal speeches and discussions.

**Terminology.** Terminology was another point at issue. When this type of care first started in the 1920's, it was known as "visiting housekeeper service." In 1939 at a conference called by the Children's Bureau representatives of a group of agencies providing the service decided that "supervised homemaker service" was a broader term connoting greater dignity. Several years later, however, the National Committee on Homemaker Service—which was founded at the Children's Bureau meeting—dropped the word "supervised" using simply "homemaker service." For the purpose of the National Conference the term "homemaker *services*" was used to include all types of "home help" service.

Although some dissatisfaction has been expressed with the term "homemaker service," it continues to be generally used throughout the United States and Canada. However, two new titles were suggested at the conference, "family aide" and "home aide," as being more descriptive of the service and perhaps more acceptable to those using it.

### *Followup*

At the close of the conference the question frequently heard was "where do we go from here?" A written report would be published in book form, but this was not enough. How was the stimulus the conference had generated to be put into action?

The conferees agreed that the extension of homemaker services would require a vigorous partnership between public and voluntary organizations in both the health and welfare fields and on National, State, and local levels. Some suggestions were:

1. That the executive committee of the National Conference on Homemaker Services plan a multidiscipline evaluation of the variations in homemaker services existing today.

2. That a continuing national mechanism be established, through the cooperative effort of all levels of voluntary and official agencies, to study such programs and to help communities interested in developing or expanding them.

3. That conference findings be brought to the attention of all State departments of health and welfare, national voluntary health and welfare agencies, and their local affiliates.

4. That the 1960 White House Conference on Children and Youth and the 1961 White House Conference on the Aging include discussions of homemaker services.

5. That the National Committee on Homemaker Service provide national leadership for coordination, stimulation, and research in homemaker service, broadening its membership, if necessary, to include disciplines not now represented.

6. That the Department of Health, Education, and Welfare continue and expand the consultative service it is presently providing the States.

Thus did the conferees accept Mrs. Oettinger's charge, made at the opening session, to keep their eyes on goals in their efforts to chart "the future course of homemaker services in this country."

The day after the conference the National Committee on Homemaker Service held its annual meeting in Chicago, a schedule planned to provide for immediate followup discussion of the conference. This resulted in a resolution that the National Committee and the executive committee of the conference arrange to meet in the near future with representatives of the sponsoring groups to formulate a plan of further action.

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[1] U.S. Department of Health, Education, and Welfare: Homemaker services in the United States, 1958; 12 statements describing different types of homemaker services. Public Health Service Publication No. 645. 1958.

[2] ———: Homemaker services in the United States, 1958; reports of preconference study groups. Public Health Service Publication (mimeographed). 1958.

[3] Stewart, William H.; Pennell, Maryland Y.; Smith, Lucille M.; Homemaker services in the United States, 1958; a nationwide study. U.S. Department of Health, Education, and Welfare. Public Health Service Publication No. 644. 1958.

[4] U.S. Department of Health, Education, and Welfare: Homemaker and related services, 1958; a directory of agencies in the United States. Children's Bureau Publication No. 370. 1958.

[5] ———: Homemaker service. Children's Bureau Folder No. 46. 1958.

# HERE AND THERE

## *Pediatrics and Delinquency*

Some ways in which pediatric services can help prevent juvenile delinquency were discussed at an interdisciplinary conference sponsored by the American Academy of Pediatrics and the Community Council of Greater New York at Arden House, Harriman, N.Y., February 16–18. The 40 conferees included pediatricians, child psychiatrists, general practitioners, social workers, sociologists, and educators.

The immediate objective of the meeting was to formulate guidelines for local pediatric committees on delinquency prevention, which have been established in 35 States under the auspices of the American Academy of Pediatrics. The conferees recommended that the guidelines be published in a pamphlet stressing the magnitude of the juvenile-delinquency problem and the complexity and interrelationship of its causal factors.

Noting that the pediatrician who wishes to help combat delinquency can act not only as a physician in his face-to-face work with children and their families but also as a citizen in the broader field of community service, they recommended that the pamphlet also include specific suggestions on what a pediatrician can do as a practitioner and as a citizen to counter community conditions that lead to juvenile delinquency.

Among appropriate functions in delinquency prevention the participants defined for pediatricians were case finding of potential delinquents, counseling of their families, referring them to other agencies for adjunctive services, and strengthening preventive services through study and action with other citizens. They also expressed the opinion that social agencies should draw on the special skill and knowledge of the pediatricians who refer families to them for service.

The conferees also suggested that the scope of pediatric training might be broadened to embrace the family and the community and that the medical-school curriculum might include sociological, social-work, and psychiatric content, not as a separate course, but integrated into the present courses. As one teaching method, they urged the use of interdisciplinary panels in medical teaching, pointing out that such panels, with pediatric leadership, have already been used successfully in several medical schools and communities. The conferees also expressed the conviction that every pediatrician needs to know enough about the emotional problems of children to recognize symptoms of trouble and be able to refer an emotionally disturbed child for specialist care when necessary.

In view of the facts that many juvenile delinquents are members of lower-income families and that pediatricians as a rule work mostly with upper- and middle-class families, the participants explored ways of bringing more pediatric service to the lower-income populations. A promising approach to this, they suggested, is for pediatricians to play a more important role in the health programs of public schools in districts of lower economic levels.

—Lincoln Daniels

## *UNICEF Action*

The Executive Board of the United Nations Children's Fund (UNICEF), meeting in Geneva, March 2–13, adopted a new program of assistance to countries wishing to improve the care of children deprived of their own homes. The program will be based on a report prepared by the United Nations Bureau of Social Affairs in response to a resolution introduced a year ago by the U.S. Delegation to UNICEF.

Because in many countries institutional care is the traditional method of caring for children without families or for whom the natural family is unable to provide, the program's short-range aim is to help countries improve the quality of their institutional care. Its long-range aim is to help countries develop well-organized systems of social services which will help preserve and strengthen family life and foster opportunities for the healthy growth of the personality and abilities of the child. Preventive services such as day care will be especially stressed.

In approving the program the Board made it clear that technical guidance must come from the Bureau of Social Affairs, which should employ a qualified child welfare worker for the purpose.

With a $135,000 financial limitation for the first year, the program will put first emphasis on training of personnel.

Also before the Board at the March meeting was a proposal to extend aid to primary education. While this was not approved in principle, some increased emphasis was authorized for training teachers in the fields of traditional UNICEF interest such as health, nutrition, hygiene, and home economics.

Over $10 million in assistance to 71 specific programs in 50 countries and territories was endorsed. Recipient governments committed themselves to spend over $32 million of their own funds on the programs.

—Katherine Bain

## *Juvenile Delinquency*

Delinquency among the District of Columbia's Negro children dropped sharply in the period 1954–58, while delinquency among white children remained practically stable, according to the District government's Interdepartmental Statistical Committee. In 1954 the delinquency rate for Negro children—the number dealt with by the police or court for delinquent acts per 1,000 Negro children aged 5 through 17—was 37.1; in 1958 it was 21.2. The rate for white children was 15.3 in 1954 and 15.2 in 1958.

During this period the Negro population in the 5 to 17 age group grew from 69,000 to 93,500, but the number of Negro delinquents dropped from 2,562 to 1,980. The white population in the same age group dropped from 62,000 to 52,000, while the number of delinquents fell from 946 to 792.

In commenting on these figures the committee pointed out that developments in the District during this period included: the creation of a youth council, which works mainly through citizens' area boards; the establishment of additional institutional facilities for care of delinquents, enabling

the department of public welfare to accept more delinquents from the court and to give them longer and better care; and creation of a youth-aid division in the police department.

The period coincides with the first 4 years of racial integration in the District's schools.

## *Family Allowances*

Government allowances to families with children are payable in 38 countries, and health and maternity insurance programs in 59, according to a survey made by the Social Security Administration's Division of Program Research. Family allowance programs, found mostly in Europe, have spread fairly rapidly, according to the information gathered. In some countries—mainly Scandinavian countries and members of the British Commonwealth—the allowances are paid to all resident families with one or more children. Elsewhere, for the most part, the allowances are payable for families of employed workers only. Most of the health and maternity programs provide both cash benefits and medical care to insured persons in case of sickness or maternity. About one-sixth pay only cash benefits, but in some countries medical services are furnished directly by the government under a separate program applying to all residents rather than to social-insurance contributors alone.

The survey showed that many of the less economically developed countries are starting health and maternity benefit programs gradually. Benefits may first be provided in the capital city, then extended to other localities as new clinics and hospitals are built.

Findings of the survey are included in the report, "Social Security Programs Throughout the World." (Price $1 from the Superintendent of Documents, U.S. Government Printing Office, Washington 25.)

## *Mental Health*

As a step toward helping State health departments to combat hereditary metabolic diseases that cause mental retardation in infants, the Children's Bureau held a meeting of one of its technical committees February 26–27 at Washington to review techniques for finding infants with phenylketonuria, a disease that usually results in brain damage if treatment is not begun early—preferably within the first 3 months of life.

Noting that the proportion of persons with the disease is relatively high among certain groups in comparison to the low incidence in the general population, the committee recommended that priority be given to testing "high risk" groups. To discover high risk families, the committee recommended that tests should be given to all patients in institutions and clinics for the mentally retarded and to persons on their waiting lists, to children in clinics for convulsive disorders, to those with eczema, and to those in special classes for slow learners. Persons in these groups in whom confirmatory tests show phenylketonuria, the committee observed, would probably be too old to benefit from treatment, but their newborn relatives may benefit if blood tests are given them and if treatment is begun at once for those who have the disease. One conferee reported that the disease can be diagnosed by a blood test as early as the 12th hour of life.

Describing their experiences with urine tests in mass screening of infants for phenylketonuria (see CHILDREN, July-August 1958, p. 158), conferees reminded the group that the results of such tests may not be positive before the sixth or seventh week of life, and that the diagnosis should be confirmed by blood tests before treatment.

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At the Harvard School of Public Health, Department of Maternal and Child Health, a study is currently in progress to inquire into the situation of children of families in which a parent has been hospitalized for mental illness. These children are assumed to have the same types of risks as other children whose fathers or mothers have been removed from the home because of death, illness, or other reasons, with the added risk factor of having lived with a parent who was mentally ill.

The study is directed toward the investigation of currently admitted mental hospital patients and their families, to determine: (1) the arrangements made for the care of the children through the family of the hospitalized parent or through the aid of social, health, or welfare resources within the community; (2) what might be done with regularity by the psychiatric hospital and other health and welfare agencies to assure the well-being of the children.

The monthly admission sheets of two Massachusetts State hospitals have been examined for the selection of patients between the ages of 15 and 54 who are married, widowed, divorced, or separated, and have children under 21 years of age currently living at home. A schedule of questions has been devised to elicit from the patients' hospital records indications of the children's situation and of arrangements that have been made for their care during the parents' hospitalization. Six weeks following hospital admission an interview is conducted with the patient's most closely concerned relative or the patient himself if he has already been released from the hospital, or both. A second interview is carried out 6 months after the hospital admission date. Each interview is conducted according to the same schedule of questions, with the emphasis in the 6-month interview on changes that have taken place.

. . .

Recommendations for State action for the mentally retarded have been issued by the Council of State Governments in the report of a conference called last fall by the Council's Interstate Clearing House on Mental Health. Among the 72 conferees were a number of State legislators and specialists in the fields of education, welfare, health, mental health, and employment, from State and National voluntary and public agencies.

Pointing out that the problems of the mentally retarded require concern from several departments of State government they urged, among other steps: that each State establish an interdepartmental group for joint planning of services for the mentally retarded; that major emphasis in institutional placement be put on voluntary rather than judicially determined admissions; that cases in judicial proceedings for commitment be referred to appropriate community resources for medical, psychological, and social diagnosis and evaluation; that State funds be appropriated for research on a continuing basis; that localities be required to provide programs for the educable mentally retarded and be permitted to provide programs for the trainable, the additional costs to be borne by the State; and that State agencies with programs for

the mentally retarded carry on inservice training for personnel.

## *Recreation*

As a step toward helping parent groups in middle-income cooperative housing developments to provide high-standard recreation programs for children, the Play Schools Association, New York City, and the city department of health are carrying on the second 2-year phase of a pilot project for helping families to adjust to group living. The project is supported by foundation funds.

In the first 2-year period, completed in 1958, recreation programs were operated and financed by more than 25 volunteer parent groups in 8 housing "cooperatives," with a total of more than 7,500 families. The program, which involved 3,342 children, from 2½ to 16 years of age, included cooperative nursery schools, summer day camps, after-school play groups, preteen clubs, and teenage social and lounge groups. The project consultants helped the parent groups to survey the community to find out about children living there; hold educational meetings and workshops; develop an effective, organized structure for activities; explain standards set by city licensing agencies; supervise the programs; and work toward the development of good relations between the cooperative and other families of the neighborhood.

In the next 2 years the project will establish a central information and education bureau to provide interpretive materials, workshops, and leadership training sessions to help housing cooperatives with community activity programs; test with the prospective tenants of a project under construction whether families can be helped to adjust to their new homes by anticipating problems; explore new techniques for the constructive harnessing of the resources of different ethnic and economic groups within the community.

An 80-page report on the first 2 years' work may be obtained from the Play Schools Association, 41 West 57th Street, New York 19, at 75 cents.

## *Fluoridation*

Although most of the largest cities in the United States now add fluorides to their water supply as a step toward preventing dental caries in children, the rate at which communities are initiating water fluoridation programs has been declining steadily in the past 6 years, according to the Public Health Service. Since 1953, the peak year for the spread of this public health measure, when 243 communities began fluoridation, the number of communities per year initiating such programs has dropped considerably. Only 110 places began fluoridating in 1957 and only 131 in 1958. The Service attributes the slowing down in the rate of community acceptance of fluoridation programs to two circumstances: the organization of opposing forces and the fact that those communities which normally adopt new health measures quickly had already introduced fluoridation by 1952.

More than 41 million people in this country (about one-fourth of those served by community water supplies) are drinking water containing at least the minimum of fluorides recommended for dental caries prevention, according to the Service. Of these, about 7 million live in places where the water is naturally fluoridated.

Most of the 34,600,000 people drinking water to which fluorides have been added live in the larger cities, the Service notes. Sixty-six percent of cities with populations of more than half a million, and 32 percent of those with populations of 10,000 to 500,000 have fluoridation programs. But among places with populations of 2,500 to 10,000 only 17 percent have such programs, and in those with populations of less than 2,500, only 5 percent.

After extensive epidemiological studies and the observation of three controlled experiments, the Public Health Service endorsed the fluoridation of public water supplies in 1951. Thirty-one national and international organizations have followed suit.

## *Toy Safety*

A toy safety committee, established last fall by the Home Conference of the National Safety Council, has offered to serve as a clearinghouse for complaints about unsafe toys. The committee will relay the complaints, along with suggested safety standards for the toys in question, to the Toy Manufacturers Association of America, Inc., which is cooperating with the committee in efforts to reduce the danger potential in toys.

The clearinghouse plan was made at the committee's second meeting, held in New York in mid-March to coincide with the association's annual Toy Fair, thus giving the committee members an opportunity to view the toys which will be on the market for the next Christmas shopping season. Recognizing that with a few notable exceptions, such as lead or lead-painted toys, the danger in toys lies chiefly in their misuse, the committee decided to devote its main efforts to urging professions and organizations having contact with parents to educate them in the principles of toy safety.

Parents, the committee warns, should learn the importance of: selecting toys appropriate to the child's age, interest, and mental and physical abilities; avoiding all toys made of lead or colored with lead-based paint; teaching and supervising children in the proper handling and potential dangers of specific toys, such as chemical sets, electrical toys, and bicycles; inspecting toys frequently to see whether misuse has rendered them unsafe; immediately repairing or discarding defective electrical toys.

In regard to toy construction, the committee recommends among other principles: building toys substantial enough to withstand investigation of construction by the user; one-piece construction for horns, whistles, and other toys used by small children; making toys for babies and toddlers washable, large, light in weight, and of nonbrittle material. The Toy Manufacturers Association has offered to publish articles on toy safety in its trade journals.

Members of the toy safety committee represent the Children's Bureau and the Public Health Service, U.S. Department of Health, Education, and Welfare; the American Academy of Pediatrics; the American Medical Association; two large insurance companies; a State health department; and the Girl Scouts of America; with the legal council of the Toy Manufacturers Association serving as liaison. The committee can be reached through the National Safety Council, 425 North Michigan Avenue, Chicago 6, Ill.

## *Professional Cooperation*

Progress in achieving greater cooperation between the legal and the social work professions requires "programs of experimentation, study evaluation, and cooperative consultation" by

appropriate National, State, and local organizations, according to a committee of lawyers and social workers appointed in 1956 by the Family Service Association of America to explore ways of improving relations between the two professions.

Among the difficulties the committee has found in the way of cooperation between the two professions in the interests of clients and community is the "linguistic barrier" set up when the lawyer uses too much legal terminology and the social worker too many terms drawn from the behavioral sciences and psychoanalysis. It also notes a frequent confusion on the part of social workers as to what is admissible evidence. Another item of difference between the two professions, according to the committee, lies in the fact that information given by the client to a lawyer cannot be used as testimony in a court proceeding, but that given to a social agency can. The committee urges bar associations and social agencies to devise measures for mutual reporting between lawyer and social agency of what happened in the client's case.

Among the sources of cases that use the services of both lawyer and caseworker, the committee points to marital conflict, which is likely to involve child custody; debt, which often disrupts families; and adoption, in which the legal rights as well as the personal welfare of the natural and the adoptive parents and the child need to be safeguarded.

As examples of successful cooperation between the two professions the committee calls attention to the work of legal aid societies.

The committee's findings are included in a pamphlet, "The Lawyer and the Social Worker," published by the Family Service Association of America, 215 Fourth Avenue, New York 3, N.Y. (Price, 65 cents.)

## *For Youth*

The Chicago City Council recently enacted an ordinance creating a Commission on Youth Welfare to replace two official bodies, the Chicago Youth Commission and the Mayor's Advisory Committee on Youth Welfare. The new commission is charged with carrying out a comprehensive program for the welfare of youth in cooperation with "all public and voluntary agencies" engaged in providing services to youth and with promoting neighborhood councils. The council's actions resulted from recommendations made by the Mayor's advisory committee after a 2-year study of needs and services.

The ordinance makes it mandatory for all city departments to furnish the new commission with their services and information on request, and to reply in writing in regard to action taken on the commission's recommendations.

. . .

A 6-year experiment planned mainly to prevent juvenile delinquency in a specific area through a "saturation" of services, and to develop methods for doing the same thing in other places has been initiated in a section of New York's Lower Eastside by the Henry Street Settlement, with the cooperation of many other voluntary and public agencies serving young people. Represented on the board of trustees are five other Lower Eastside settlements, the Lower Eastside Neighborhoods Association, and the Lower Eastside Mission of Trinity Parish. The population of the project area, estimated at 115,000, includes 15 well-identified, highly delinquent gangs, according to James E. McCarthy, the project director.

Called "Mobilization for Youth," the project will: (1) supplement existing services with additional ones—psychiatric, psychological, casework, groupwork, educational, recreational, and others; (2) organize community and neighborhood leadership; (3) carry on social research through a separate unit. It is expected to cost $1,250,000 a year. Some funds have already been received and others are being sought from public and private sources.

Public agencies pledged to cooperate with the project include the city youth board; the board of education; the departments of health and welfare; the police department; the courts, including their probation departments; and correctional institutions.

The research unit of the project has been established under the auspices of the New York School of Social Work, Columbia University.

## *Premature Babies*

Data collected during a study of the effects of a specific nursing practice on premature infants are being analyzed by the Division of Nursing Resources, Public Health Service.

Over an 8-month period the progress of 40 premature infants with a rolled diaper body support was observed and compared with that of 40 infants of similar sex, race, and birth weight who did not receive such support. The birth weights of the infants studied ranged between 1,000 and 2,000 grams.

Every 10 minutes, 24 hours a day, for the first 42 days of life, observers recorded each baby's sleep and vocal behavior, as well as body movements, and the type of care given and by whom (registered nurse or nurse's aid). Each baby's weight, body temperature, eating ability, caloric and fluid intake, and vomiting were recorded daily.

Preliminary review of the findings suggests that the diaper roll may contribute indirectly to the baby's welfare by increasing sleeping time and reducing crying, but that it does not contribute significantly to weight gain.

## *Facts and Figures*

In 1958, for the first time since 1950, the number of infants born in the United States apparently decreased, according to provisional figures of the National Office of Vital Statistics. These indicate that about 4,248,000 babies were born in 1958, a decline of 53,000, or 1 percent, from the record high set in 1957. A reduction in marriages of 4 percent in 1957 accounts for one-fourth of the estimated decrease. The estimated number of first-born children who arrived in 1958 was 1,151,000, compared with 1,164,000 in 1957.

The provisional infant mortality rate for 1958 was 26.9 deaths of infants under 1 year of age per 1,000 live births; for 1957 the provisional rate was 26.4. Deaths of infants in the first month of life rose from an estimated 19.0 per 1,000 live births in 1957 to 19.4 in 1958.

. . .

In 1957, for the first time in about a quarter of a century, the maternal mortality rate in the United States failed to decline. That year the rate stood at 4.1 per 10,000 live births, the same as in the previous year. Maternal deaths in the country as a whole numbered 1,746 in 1957, as compared with 1,702 in 1956.

Between 1929 and 1956, the death rate among mothers due to complications of pregnancy, childbirth, and the puerperium steadily declined from 69.5 to 4.1 per 10,000 live births.

# BOOK NOTES

INDUSTRIAL SOCIETY AND SOCIAL WELFARE; the impact of industrialization on the supply and organization of social welfare services in the United States. Harold L. Wilensky and Charles N. Lebeaux. Russell Sage Foundation, New York. 1958. 401 pp. $5.

This study of why and how welfare institutions and the profession of social work have developed in the United States—written by a professor of sociology and a professor of social work—is an extension of a monograph first prepared as a commission report for the Eighth International Conference of Social Work held in Munich in 1956.

Part 1 of the book discusses social problems caused by industrialization and urbanization from the days of the industrial revolution to the present, including discussion of the effects on the family of worker dependence on the state of the labor market, changes in the nature and bases of specialization, and the vastly increased mobility these impose on the worker.

Noting how the problems of industrialization have led to establishment of welfare services, Part 2 reports on the auspices and expenditures of existing services, discusses changing problems in family service, and analyzes various theories in regard to juvenile delinquency.

The authors point to two conflicting concepts of the function of social welfare institutions—the *residual*, which regards them as coming into play only when the normal structures break down, and the *institutional*, which regards them as normal "first line" functions of protection. They see family service as broadening to include a new clientele, the middle class; making increasing efforts to deal with problems of adjustment on a mass scale through social hygiene techniques; and being faced with the responsibilities of reaching families in far-flung suburbia.

Part 3 indicates how industrialization affects the organization of welfare services and describes the development of social work as a profession. The authors refer to the rise of hierarchal structure and of specialization in social work and their effects on service, the place of pressure groups in the formation of welfare policy, the withdrawal of board membership from involvement in day-by-day agency affairs, and the increasing control of fund-raising by the business world. They present some of the elements which delimit and define social work as a profession, and discuss the recurrent questions of the compatibility of professionalism with commitment to reform and what the proper relation of the professional social worker is to the policy maker.

THE PROBLEM OF DELINQUENCY. Sheldon Glueck, editor. Houghton Mifflin Co., Boston. 1959. 1,183 pp. $10.50.

Planned to assist in training prosecutors, judges, probation and parole officers, clinicians, social workers, and others in the field of juvenile delinquency, this book presents nearly 200 papers discussing the multiple forces and factors in the problem of juvenile delinquency. They are divided into four groups: on the incidence and causes of delinquency; the juvenile court and the law; treatment of the delinquent; and prevention of delinquency. A section is included on youthful offenders who are beyond juvenile-court age.

The authors represent a wide range of disciplines, such as social and physical anthropology, sociology, psychiatry, psychoanalysis, psychology, the law, and social work.

THE PSYCHOANALYTIC STUDY OF THE CHILD, Vol. XIII. Edited by Ruth S. Eissler and others. International Universities Press, New York. 1958. 582 pp. $8.50.

Included in this collection of theoretical papers and clinical reports are a number of discussions of the childhood psychological needs of the gifted, of normality and pathology in adolescence, and of the effects of early mother-child relationships on a child's personality development.

The volume includes 22 major papers, four of them, with following "discussions," from the Ernst Kris Memorial Meeting, held in 1957 in New York by the New York Psychoanalytic Society and Institute and the Western New England Society and Institute. The remaining papers are divided into four sections: "Contributions to Psychoanalytic Theory," "Aspects of Normal and Psychoanalytic Development," "Clinical Contributions," and "Applied Psychoanalysis." The book also includes a list of the writings of Ernst Kris and the tables of contents of the 12 previous volumes.

NUTRITION IN HEALTH AND DISEASE. 13th ed. Lenna F. Cooper, Edith M. Barber, Helen S. Mitchell, and Henderika J. Rynbergen. J. B. Lippincott, Philadelphia. 1958. 734 pp. $6.

The new edition of this textbook for students of nursing includes some changes of special interest to child-health workers, notably in the chapter dealing with nutrition in diseases of infancy and childhood. Without shifting the focus from the sick child to his illness, the authors have introduced additional material on the nutritional problems of crippled children and have also dealt briefly with the recently recognized inborn errors of metabolism that if untreated are likely to result in mental deficiency.

MENTAL SUBNORMALITY; biological, psychological, and cultural factors. A survey of research sponsored by the National Association for Retarded Children. Basic Books, New York. 1959. 442 pp. $6.75.

This book includes two reports, previously published separately, "The Prevention of Mental Subnormality" by Richard L. Masland, M.D., and "Psychological and Cultural Problems in Mental Subnormality" by Seymour B. Sarason, psychologist, and Thomas Gladwin, anthropologist. (See CHILDREN, May–June 1958, page 115.) The first report reviews studies concerned with the physical causes of mental retardation—genetic, intrauterine, and postnatal; and the second, studies concerned with the cultural and environmental factors in mental retardation.

# IN THE JOURNALS

## *Intercountry Adoptions*

How a U.S. Army hospital in West Germany works with a German child-placing agency to safeguard children and adoptive parents in the placement of children with American Army couples is reported by the hospital's psychiatric social worker in the March 1959 issue of *Social Casework*. ("Casework Consultation in Overseas Adoption," by Frank F. Montalvo, First Lieutenant, U.S. Army.) The program was begun after hospital authorities learned about the mistreatment of some adopted children by severely disturbed adoptive parents and of other children being placed for adoption who were severely disturbed themselves.

Now, according to the author, the local agency requires every American couple applying for a child to obtain from the Army hospital a certificate stating that the two are in good mental and physical health and that they have received "preadoptive counseling." Before the adoption takes place the hospital pediatrician examines the child to discover any conditions that might interfere with his later development.

## *Respiratory Illnesses*

A newly recognized group of viruses, known as hemadsorption viruses, apparently are responsible for 50 percent more cases of acute respiratory disease among infants and children than is influenza, according to the findings of a study carried out by the Public Health Service's National Institute of Allergy and Infectious Diseases and the Research Foundation of Children's Hospital in Washington, D.C.

The study included examination of throat swabs from 1,738 hospitalized children of low-income families during 1957–58, including patients with respiratory illness and controls, and found two strains of the hemadsorption (HA) viruses associated more frequently with the sick children. Type 1 was associated most frequently with pneumonia, croup, bronchiolitis, pharyngitis, and mild respiratory tract disease; type 2 with croup, pharyngitis, and the mild illness, with croup showing the highest rate of association. The HA viruses were shown to be responsible for about 20 percent of the total respiratory illnesses studied, and for 42 percent of the croup cases.

The techniques of the study were reported in detail in the February 7, 1959 issue of the *Journal of the American Medical Association* by the seven investigators involved.

## *Institution Administrator*

The first responsibility of a children's institution is to give each child the opportunity to establish roots, even if only temporarily, in an atmosphere created by warm, affectionate persons who can fulfill his needs for love, security, and understanding, says Helen R. Hagan, assistant executive director of the Child Welfare League of America, in *Child Welfare* for March 1959. ("The Administrator's Responsibility: Developing Program To Meet Varying Needs of Children.") Among other needs the institution must try to fulfill for children, she cites the need for satisfaction through accomplishment, for experience of the world outside the institution, and for treatment of problems interfering with normal development.

The administrator must assume the role of leader in fulfilling these needs, says the author, identifying in this role a number of specific functions: the accountability for a total program of individual and environmental treatment; the recruitment, screening, employment, orientation, and retention of properly qualified staff in various disciplines and evaluation of their work; the establishment of channels of communication among the staff, between staff and administrator, and between administrator and board and community.

Maintaining that other types of child welfare services in the community obviate the need of institutional care for "normal" little children, she points out that other children desperately require types of institutional services that are not sufficiently available—the physically handicapped child who needs special training, the mentally retarded, the emotionally disturbed, and the adolescent who cannot get along in a foster family.

## *Accident Prevention*

Doctors, hospitals, and medical societies should carry on a steady, year-round program for educating parents in accident prevention, says Forrest P. White, M.D., in the *Virginia Medical Monthly* for March 1959. ("The Physician's Responsibility in Childhood Accident Prevention.") Warning against the kind of program which might cause parents to develop such neurotic concern that they constantly hover over the child, he advocates encouraging them to make the environment so safe that they can relax in the reasonable assurance that their children will not be injured.

Recognizing, however, that there are times when vigilance is needed, the author also urges physicians to teach mothers about the dangers in such practices as holding a lighted cigarette and a baby at the same time or leaving the baby in a bathtub while answering the telephone.

## *One-Parent Families*

A 5-year group discussion project enabling widowed and divorced parents to exchange views on the problems of bringing up their children is described in *Social Work* for January 1959 by Kurt Freudenthal ("Problems of the One-Parent Family"). The discussions, sponsored by the Baltimore Board of Education and led by the author, a social worker, were carried on in 30 weekly sessions each school year. An average of 50 parents, three-fourths of them mothers, participated.

Several factors in one-parent families were noted frequently, says the author, which involved both parent and child: a sense of incompleteness and frustration; a sense of guilt and failure; and mixed feelings of hostility and love toward each other.

The author suggests the possibility of conducting similar group sessions for parents receiving assistance payments under programs for aid to dependent children and special emphasis in inservice training of ADC workers on the problems of the parent who is bringing up a child or children alone.

# Readers' Exchange

**STITT et al.:** ***Some questions***

In their description of the Family Health Clinic in Boston, Dr. Stitt and her colleagues emphasized a stimulating point when they maintained that the pediatrician can be more effective in his help to mothers if he becomes acquainted with them during the prenatal period. [See "Teamwork in Helping Families To Launch a Life," by Pauline G. Stitt, Joan G. Babbott, and Eva J. Salber, CHILDREN, March–April 1959.]

However, in respect to their aim of bridging the gap between the obstetric and the pediatric phases of family health counseling, they failed to discuss what is probably the most critical period to most mothers—the days in the hospital and the first weeks at home—a time when the pediatrician has a unique opportunity for carrying a desperately needed supporting role. This is relevant to the philosophy expressed by the authors in phrases such as "timely measures," "sense of the moment," "the crises of pregnancy and child rearing," and "the way in which each new challenge is met has immediate and long-range effect." I hope the day will soon come when a home visit by a physician will be a routine feature during the first week or two of the baby's life.

Since a clinic is not really a "family clinic" if the fathers are not successfully involved, Dr. Stitt and her colleagues more properly referred to the service they describe as an "obstetric-pediatric clinic." In certain countries, the term "puericulture center" is used. It is impracticable in this country and probably inadvisable to establish the type of family clinic organized in some parts of the world under WHO demonstrations where entire households, including fathers and grandparents, can go for all their medical needs. But we should at least be able to schedule practice, private or clinic, to include an evening or Saturday morning group discussion among fathers.

Mothers often have charged that pediatricians tend to dispense advice as if the one child under discussion at the moment is their only child. In mentioning the undesirability of "overelaborate attention to one child," Dr. Stitt and her colleagues whet our appetites for more details on how "practices geared to stages in children's motor, social, and adaptive development" can be established in the family that includes several children, each in a different stage of motor, social, and adaptive development.

In closing, the authors recognize that varying amounts and components of the clinic described might be adapted to other settings. Many questions remain to be answered: Is the multidisciplinary approach feasible or desirable as the general pattern of family counseling? To what extent should the various disciplines give direct service, and how many of them might preferably join the psychiatrist in a consultant capacity? When does the law of diminishing returns set in in the advantages that accrue to the members of the team from their association with each other? Other than in a research and training situation, would the cost per family not be prohibitive? Would it not be desirable to use general practitioners, so that at least the medical components could be unified in one individual who would have access to obstetric, pediatric, and psychiatric consultants?

*Samuel M. Wishik, M.D., Professor, Maternal and Child Health, Graduate School of Public Health, University of Pittsburgh.*

***Lucky families***

The value of the type of multidisciplinary experience described by Dr. Stitt and her coworkers in furthering mutual respect and understanding among the various professional disciplines is self-evident. Exposure to such a concentrated family-centered setting early in the period of graduate training should do much to promote favorable career-long working relationships among members of the various professions represented on the team.

The families seen at the Family Health Clinic are fortunate indeed. Only 116 families having their first babies and 25 of the same families during and after subsequent pregnancies were seen at the clinic over a 6-year period. Even if the clinic met only once a week, this would represent a tremendous concentration of high-powered personnel time. This is hardly a demonstration service in the sense of setting a pattern that might be followed even partially in a public maternal and child health program. The concentrated approach should be considered only as a research or training situation.

Since the focus of the article is on the pediatrician's contribution to family-centered care, the place of the obstetrician remains rather obscure. It would be of interest, for example, to know how long the obstetrician functions as a member of the team after the birth of the infant. No mention is made in the article of the management of delivery itself and whether or not there is any carryover from the clinic to the hospital delivery and postpartum experience. Lack of involvement of the clinic obstetrician and pediatrician in the hospital would leave a serious gap in the continuum of care.

*Edward R. Schlesinger, M.D., Associate Director, Division of Medical Services, New York State Department of Health.*

**WERTHEIM:** ***More about fathers***

In commenting on my article "A Joint-Interview Technique With Mother and Child" [CHILDREN, January–February 1959], J. McV. Hunt asks: "What about fathers?" [CHILDREN, "Readers' Exchange," March–April 1959.] On theoretical grounds, where the family is basically intact, the inclusion of fathers and sometimes siblings would be the approach of choice. The limitation of the joint interview to the mother and child as described in the article was due at the time to practical difficulties in bringing the fathers to the clinic for frequent sessions. In most cases a close contact with the fathers was maintained with occasional joint family or parent interviews. The handling of the total field of family relationships proved clinically superior to dealing with a limited sector only.

The mother-child dyad was made the focus of the report because the dynamics of this combination in a clinical setting

had been explored more fully than the total family group. The observations described were derived from daily clinical experience. Systematic evaluations properly sought by Professor Hunt are not yet available. The challenging possibilities evident at this exploratory stage seemed to warrant a report in order to stimulate research and thinking.

As Professor Hunt pointed out, in spite of the advantages of family group therapy, in certain situations a joint interview including only mother and child may be the technique of choice. He added, "but it will be difficult to discover what these situations are without first focusing on the family as a unit."

Although therapeutic influences are implicit in the diagnostic process, I would like to emphasize at this point the importance of diagnosis per se which Professor Hunt seems to minimize. Sound diagnosis is essential in setting therapeutic goals and deciding form of treatment. It must include consideration of which family members should be involved in treatment and at which point in time. Further, it calls for a careful evaluation of the desirable and the undesirable changes the treatment is likely to produce in the total family equilibrium. The stress in the article on the diagnostic aspects of the joint-interview technique reflected this view. Improvement of diagnostic knowledge and techniques is a necessary prerequisite to a more differentiated approach to therapy.

*Eleanor S. Wertheim, Clinical Psychologist, Royal Children's Hospital, Melbourne, Australia.*

# Guides and Reports

THE ECOLOGY OF THE MEDICAL STUDENT; report of the Fifth Teaching Institute, Association of American Medical Colleges, Atlantic City, N.J., October 1957. Edited by Helen Hofer Gee and Robert J. Glaser. Part 2 of the *Journal of Medical Education*, October 1958. The Association, Evanston, Ill. 262 pp. Cloth, $3; paper, $2.

Presents discussions exploring the environmental stresses that influence the development of the future physician.

NATIONAL HEALTH COUNCIL DIRECTORY OF MEMBER ORGANIZATIONS, 1958. The Council, 1790 Broadway, New York 19, N. Y. 124 pp. $1. Special rates for quantity purchases.

Describes the purposes, program, organizational structure, publications, and source of financial support of each of 63 national public or private health agencies.

INTEGRATION—A CHALLENGE TO THE SOCIAL AGENCY; report of a workshop, June 11, 1958, sponsored by Committee on Intergroup Relations, National Social Welfare Assembly. The Assembly, New York 17, N.Y. January 1959. 25 pp. 75 cents. Quantity discounts.

At this workshop representatives of more than 30 national voluntary social agencies examined ways in which they could help their local affiliates work for racial integration within themselves and their wider communities. (See CHILDREN, September–October 1958, p. 196.)

THE CHILD AT LAW; report of the 28th Ross Pediatric Research Conference. Ross Laboratories, Columbus 16, Ohio. 1958. 104 pp. Free on request from Ross Laboratories.

Proceedings of a symposium held in 1958 at Tulane University, New Orleans, attended by representatives of pediatrics, social work, psychiatry, education, the ministry, and the law, focused on the legal aspects of the family, guardianship, adoption, delinquency, foods, drugs, and accidents, in relation to children.

REACHING OUT IN RECREATION; a practical guide to human relations techniques. Jay B. Nash, Milo F. Christiansen, and Dan W. Dodson. School of Education, New York University, Washington Square, New York 3; and Division of Youth Services, American Jewish Committee, 386 Fourth Avenue, New York 16, N.Y. 1958. 20 pp. 20 cents. Quantity prices on request.

Presents real-life problems involving integration of minority and majority groups in public recreation programs and describes efforts to solve them; also lists 12 guidelines for leaders in situations involving groups of different backgrounds.

THE NONOPERATIVE ASPECTS OF PEDIATRIC SURGERY; report of the 27th Ross Pediatric Conference. Ross Laboratories, Columbus 16, Ohio. 1958. 96 pp. Free on request from Ross Laboratories.

In addition to technical discussions of procedures, this report of a conference held in 1957 at the Ohio State University College of Medicine, Columbus, Ohio, includes discussions of preparation of a child for surgery, his emotional reactions to surgery, and play programs for the hospitalized child.

THE LITTLE BOY WHO HAD TWO BIRTHDAYS. Martha Helen Sullivan. St. Anthony Guild Press, Paterson, N. J. 1958. 12 pp. 35 cents.

A story for children of a happy adoption, written as an aid to parents in helping an adopted child understand and feel good about the fact of his adoption.

YOUTH IN COMMUNITY AFFAIRS. National Social Welfare Assembly, 345 East 46th Street, New York 17, N. Y. 1958. 15 pp. 20 cents in lots of 25 or more; 25 cents a copy.

A summary of discussions that took place at a 4-day meeting of 60 boys and girls 15 to 19 years of age, which was called at New York by the National Social Welfare Assembly this year to bring out the young people's opinions on teen-agers' participation in community affairs.